

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-320 71 4001				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 71 4001	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH			
				REITZE, FREDERICK C.		4/22/71		11:45 P.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hospital				A. STATE					
				Md. Balto.					
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore					
				D. STREET ADDRESS (If rural, give location) 106 Forest Drive					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.		
Male	White	Married	11/5/95	75					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retired						Maryland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Justus Reitze				Louise					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
WW1				215-24-6613		Elizabeth Reitze 106 Forest Drive			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) Non-specific ulcerative colitis					
ANTECEDENT CAUSES				(B)					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)					
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				No					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 4:15 19 71 to 4:22 19 71, that (I) (we) last saw the deceased alive on 4:22 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE				M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
J. Gerard Crowley								4-22-71	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
J. Gerard Crowley				Maryland General Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)	
Burial		4/27/71		Woodlawn Cemetery		Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS					
APR 26 1971		Robert E. Taylor, M.D.		Witzke, 1630 Edmondson Ave., 21228					



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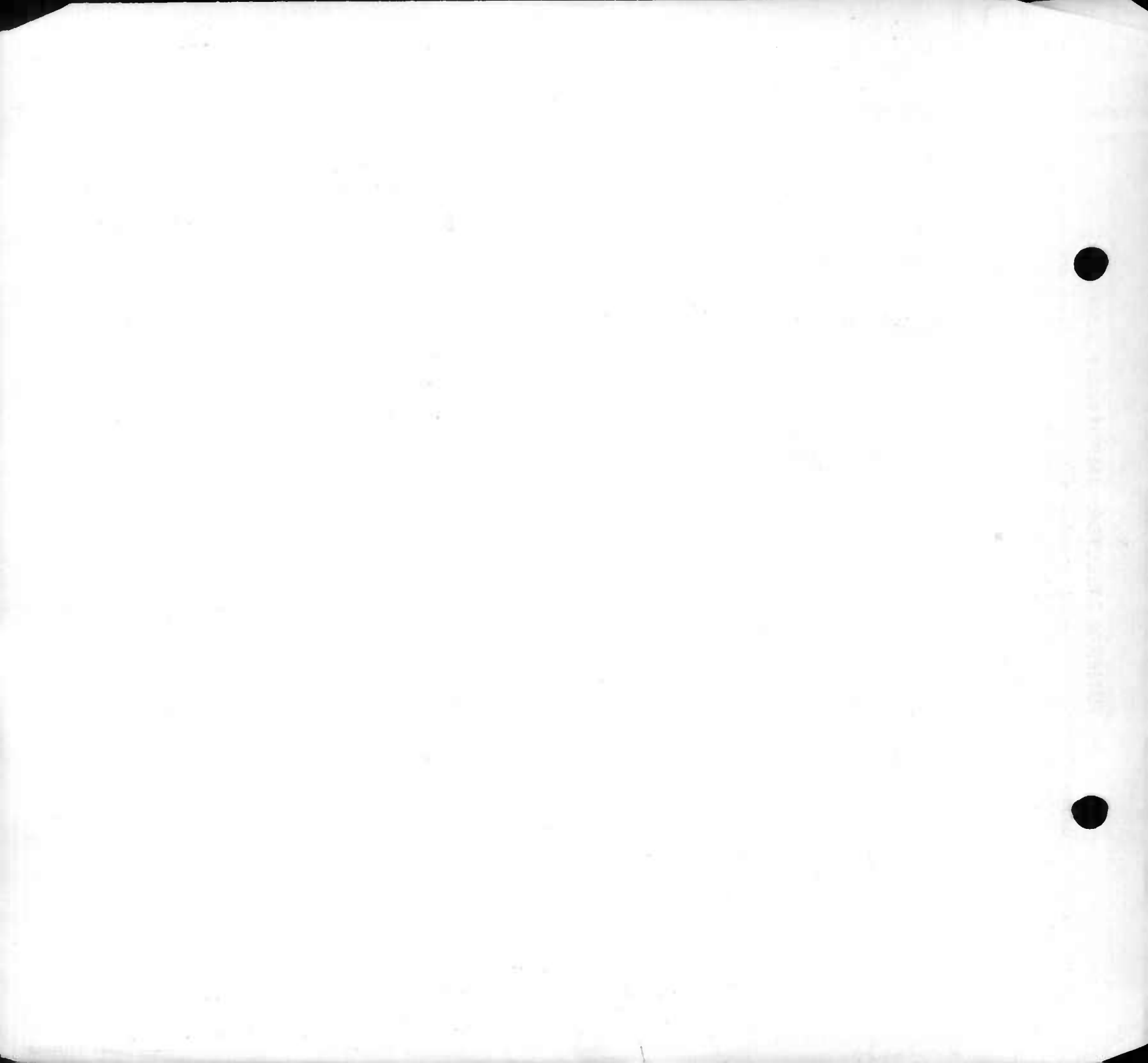
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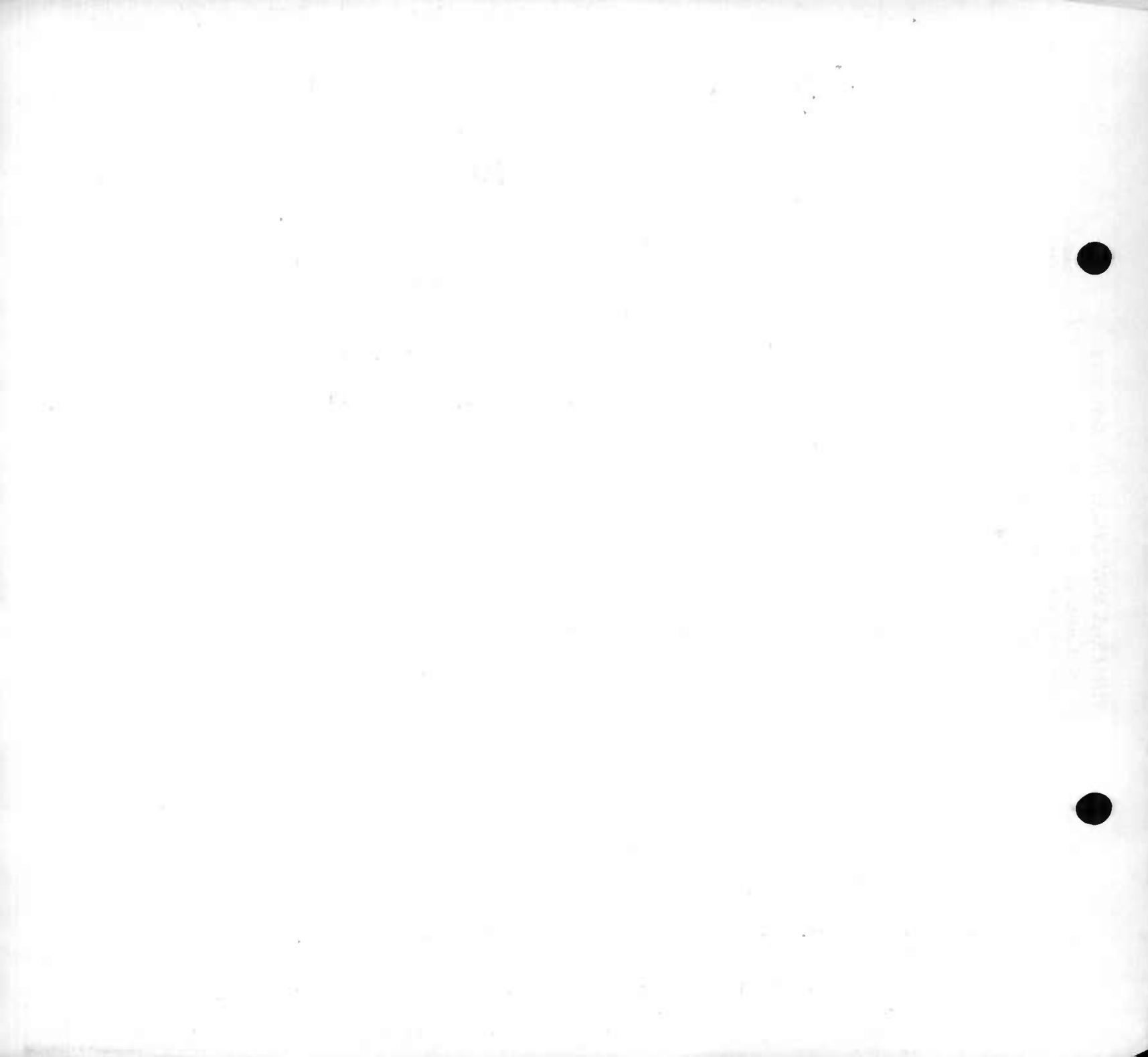
BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 71 4002	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) VOLKMAN. GEORGE P/				2. DATE AND HOUR OF DEATH 4. 23. 71 8. 15 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lutheran Hospital of Maryland				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY MD Baltimore			
5. SEX male 6. RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 10. 30. 96. 9. AGE (In years last birthday) 74			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Fireman				10B. KIND OF BUSINESS OR INDUSTRY Balto City Fire Dept		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Late John Volkman			
14. MOTHER'S MAIDEN NAME Anna Late				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO.				17. INFORMANT Mrs. Mary Volkman, 701 Raynor Ave., 21228			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE Cachexia. DUE TO, OR AS A CONSEQUENCE OF: (B) Ca Bronchus. DUE TO, OR AS A CONSEQUENCE OF: (C)			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4. 5 19 71 to 4. 23 19 71. that (I) (we) last saw the deceased alive on 4. 23 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE R. Govinda Rao				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) R. GOVINDA RAO	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 4/26/71		24C. NAME OF CEMETERY OR CREMATORY Dulaney Valley	
25A. DATE REC'D BY HEALTH DEPT. APR 26 1971				25B. NAME OF REGISTRAR Blair E. ...		25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Ave., 21228	
24D. LOCATION (City, town, or county) (State) Dulaney Valley, Maryland							



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0-540		71 4003		BALTIMORE CITY HEALTH DEPARTMENT		71 4003	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) Matthew O'Neill				2. DATE AND HOUR OF DEATH 4/22/71 9:15 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 00		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 5102 Greenwich Avenue		A. STATE Md		B. COUNTY 2854	
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 5102 Greenwich Ave.			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/13/09	9. AGE (In years last birthday) 61	10. If Under 1 Yr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY Sealtest		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Late Matthew O'Neill				14. MOTHER'S MAIDEN NAME Late Anna Upler			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-03-3706		17. INFORMANT ADDRESS Mrs. Margaret O'Neill, 5102 Greenwich Ave.			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of Rectum		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(B) DUE TO, OR AS A CONSEQUENCE OF: Arterioscl. Cardio Vasc. Disease			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9-30-1966 to 4-22-1971 that (I) (we) last saw the deceased alive on 4-21-1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Dr. Harry L Knipp				23B. DATE SIGNED 4-23-71			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS 4116 Edmondson Ave. Balto, Md. 21229		23E. MED. DIRECTOR Witzke, 1630 Edmondson Ave., 21228			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/26/71		24C. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 26 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Ave., 21228		ADDRESS	



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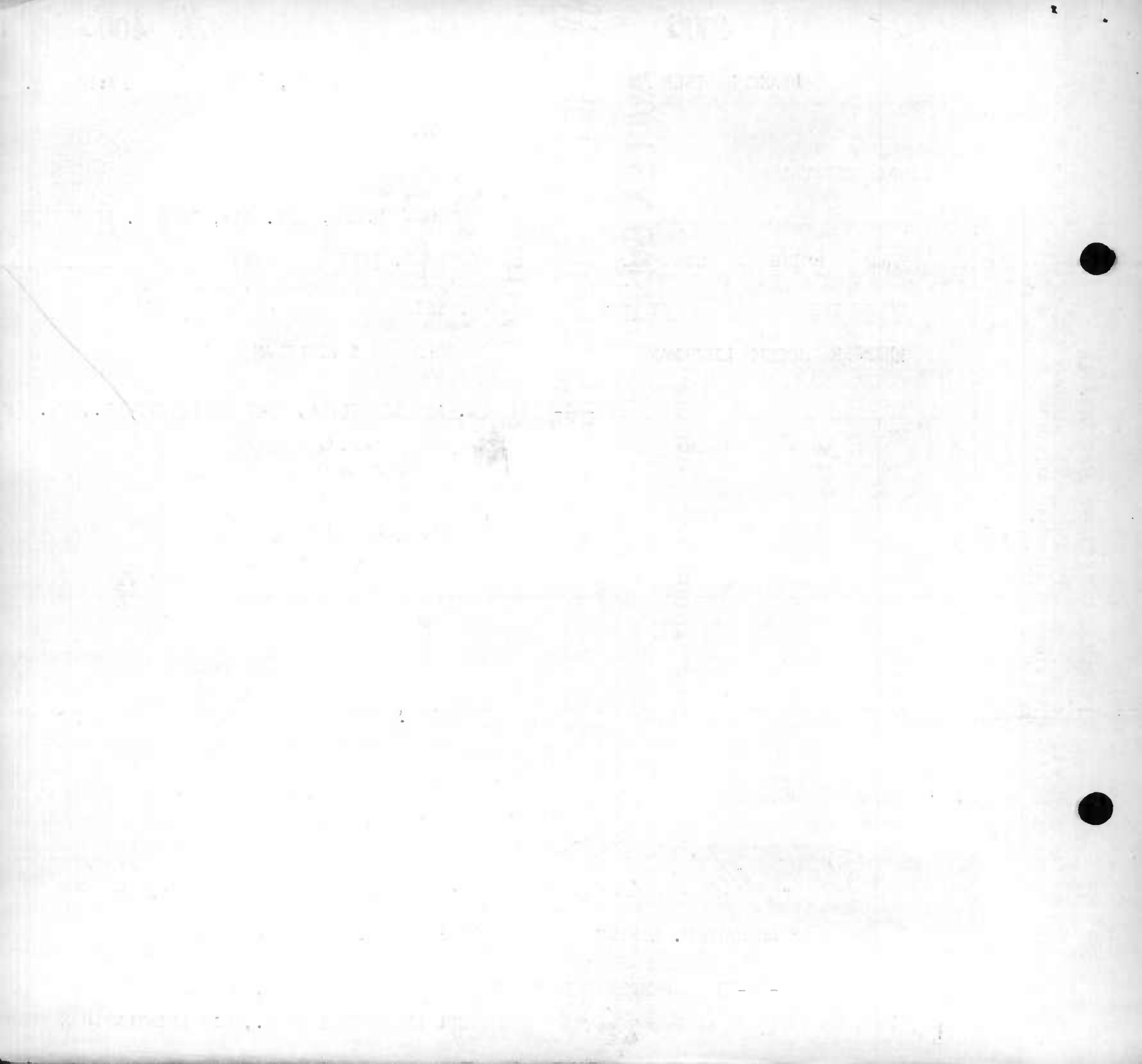
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4004	
BIRTH NO. 1-500 71 4004		CERTIFICATE OF DEATH			
1. NAME OF DECEASED <small>(Type or Print)</small> Ethel S. Vane			2. DATE AND HOUR OF DEATH April, 23, 1971 12:25 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital 900 Caton Avenue Baltimore, Maryland 21229			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 1950 Furnace Avenue, Elkridge 5300		
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 7-23-88	
13. FATHER'S NAME Edward A. Smith		14. MOTHER'S MAIDEN NAME Annie E. Smith West		9. AGE (In years last birthday) 82	
15. Was Deceased Ever in U. S. Armed Forces? <small>(Yes, no or unknown) (If yes, give war or dates of service)</small> no		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) Delaware	
17. INFORMANT Mrs. Sarah V. Johnson, 5003 West Hills Rd.		12. CITIZEN OF WHAT COUNTRY? USA		18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <small>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</small> CAUSE OF DEATH MARKED DEHYDRATION HYPOVOLEMIC & SEPTIC SHOCK ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) PROBABLE RUPTURED HOLLOW VISCUS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0399		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. CABILL				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) M. CABILL				23D. ADDRESS St. Agnes Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/26/71		24C. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery	
24D. LOCATION (City, town, or county) (State) Maryland		25A. DATE REC'D BY HEALTH DEPT. APR 26 1971			
25B. NAME OF REGISTRAR John E. Fisher, R.D.		25C. FUNERAL DIRECTOR Howard City Funeral Home of Harry H. Witze, 321 Columbia Pike 21043			



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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4005	
L-165 71 4005 BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BLANCHE LIBERMAN			2. DATE AND HOUR OF DEATH APRIL 19, 1971 10:10 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 42 FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2717 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER CONCORD HOUSE, APT. 314, 2500 W. BELVEDERE		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 21, 1887	9. AGE (In years last birthday) 84	If Under 1 Yr. Months: Days: Hours: Min. 12. CITIZEN OF WHAT COUNTRY? USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY AT HOME		
11. BIRTHPLACE (State or foreign country) RUSSIA			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME UNKNOWN JOSEPH LIBERMAN			14. MOTHER'S MAIDEN NAME DORA X LIBERMAN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 213-48-3784		
17. INFORMANT MR. ARNOLD MILLER, 2909 FALLSTAFF RD., APT. 41			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 4/10/71 CAUSE OF DEATH Acute Coronary Generalized Arterio Sclerosis			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1960 to 4 15 1971, that (I) (we) last saw the deceased alive on 4/7 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED 4/19/71	
23C. PHYSICIAN'S NAME (Type) LEONARD M. LISTER				23D. ADDRESS 7111 PARK HEIGHTS AVENUE	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-21-71		24C. NAME OF CEMETERY or CREMATORY HEBREW FRIENDSHIP	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. APR 26 1971			
25B. NAME OF REGISTRAR Walter E. Taylor, M.D.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			



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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4006	
S-460 71 4006 CERTIFICATE OF DEATH		BIRTH NO. 1. NAME OF DECEASED (Type or Print) LOUIS SHILLER			
2. DATE AND HOUR OF DEATH APRIL 20, 1971 8:20 P. M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BELVEDERE NURSING HOME			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2525 W. BELVEDERE AVENUE		5. SEX MALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 9. AGE (In years last birthday) 92 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT 10B. KIND OF BUSINESS OR INDUSTRY RETAIL 11. BIRTHPLACE (State or foreign country) RUSSIA 12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME ? SHILLER 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO 16. SOCIAL SECURITY NO. 187-16-9381A		14. MOTHER'S MAIDEN NAME UNKNOWN 17. INFORMANT MRS. PHYLLIS SILBERMAN, 3931 SETONHURST RD. #8 ADDRESS			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF: (B) Arteriosclerosis, Generalized DUE TO, OR AS A CONSEQUENCE OF: (C)			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes 5 yrs		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Feb 3 1970 to April 20 1971, that (I) (we) last saw the deceased alive on April 16 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE ALAN B. COHEN M.D. 23C. PHYSICIAN'S NAME (Type) ALAN B. COHEN		23B. DATE SIGNED 4/21/71 23D. ADDRESS 3501 St. Paul St.		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL-REMOVAL 24B. DATE 4-22-71 24C. NAME OF CEMETERY or CREMATORY MT. SHARON (BNAI CHAIM SECTION) 24D. LOCATION (City, town, or county) (State) SPRINGFIELD, PENNSYLVANIA	
25A. DATE REC'D BY HEALTH DEPT. APR 26 1971 25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR SOL LEVINSON, & BROS., 6010 REISTERSTOWN ROAD ADDRESS			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-652 71 4007				BALTIMORE CITY HEALTH DEPARTMENT		71 4007	
CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print) <i>Mrs. Elizabeth Barnes</i>				2. DATE AND HOUR OF DEATH <i>April 19, 1971</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD.</i> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Hood Nursing Home</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>5313 Edmondson Ave. Baltimore, Md 21229</i>		C. CITY OR TOWN <i>BALTIMORE</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>HOOD NURSING HOME 28-54</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 31-1898</i>	9. AGE (in years last birthday) <i>72</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>TEACHER</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>SCHOOL</i>		11. BIRTHPLACE (State or foreign country) <i>MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>EDWARD GREGG</i>				14. MOTHER'S MAIDEN NAME <i>MINNIE HAINES</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>E. Howard Legg - Easton, Md.</i>		ADDRESS	
18. <i>4/12/71</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>A.S.C.V.D.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>years</i>	
19A. DATE OF OPERATION <i>4/12/71</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Feb 1967</i> to <i>Apr 19 1971</i> that (I) (we) last saw the deceased alive on <i>4/18 1971</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>J. C. Pound</i>				23B. DATE SIGNED <i>4/19/71</i>			
23C. PHYSICIAN'S NAME (Type) <i>J. C. Pound</i>				23D. ADDRESS <i>3325 Frederick Ave</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		24B. DATE <i>4-21-71</i>		24C. NAME of CEMETERY or CREMATORY <i>Luther Park Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 26 1971</i>		25B. NAME OF REGISTRAR <i>J. C. Pound</i>		25C. FUNERAL DIRECTOR <i>John J. Carroll</i>			

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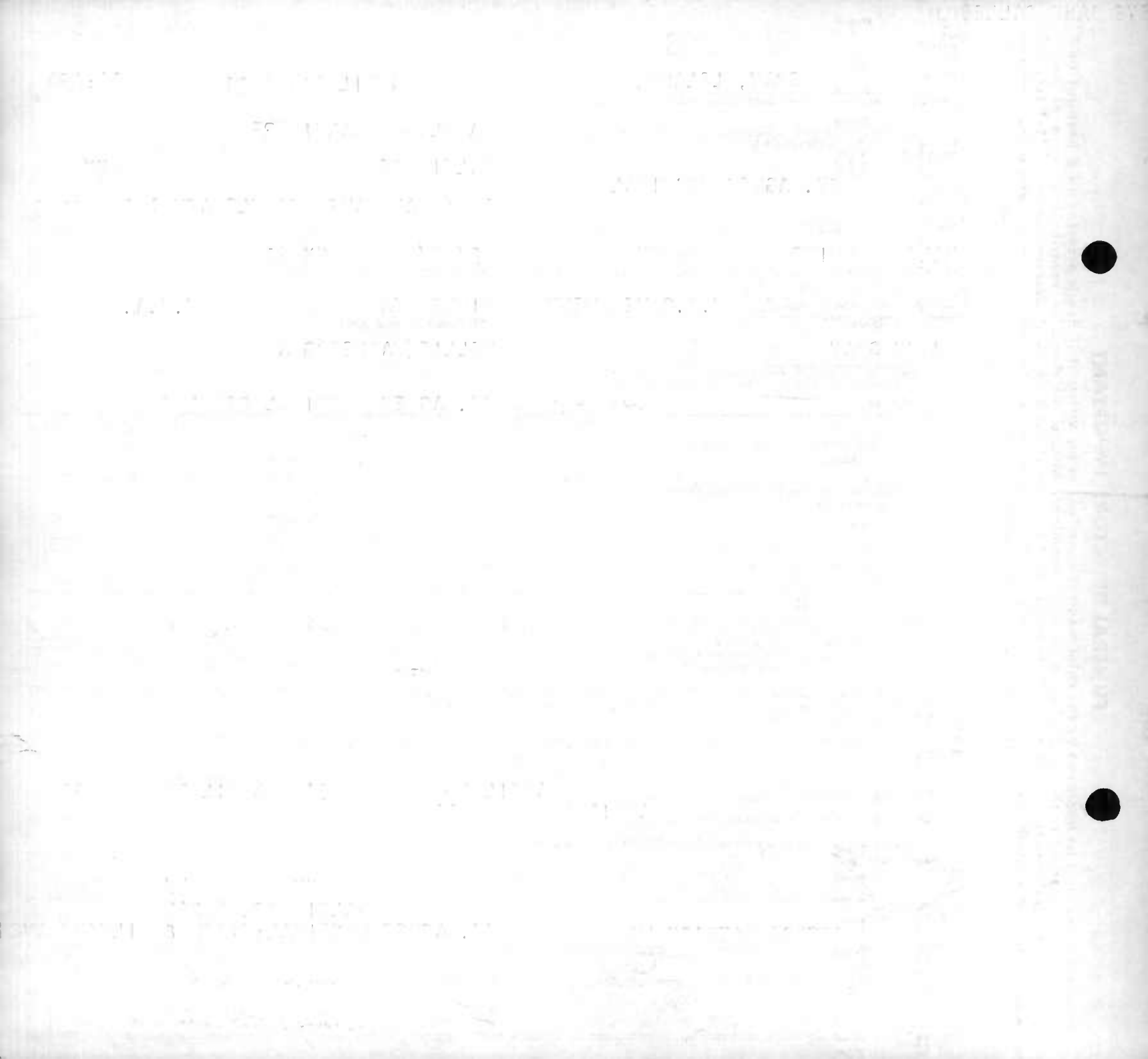
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 71 4008

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

BIRTH NO. 71 4008		BALTIMORE CITY HEALTH DEPARTMENT	
1. NAME OF DECEASED (Type or Print) GRAY, LELAND, W		2. DATE AND HOUR OF DEATH APRIL 20, 1971 11:05A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE 5300 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 7208 OAK HAVEN CIRCLE APT 103 21207	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 03/08/04
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STATISTICIAN - S.S.		10B. KIND OF BUSINESS OR INDUSTRY U.S. GOVERNMENT	9. AGE (In years last birthday) 67
11. BIRTHPLACE (State or foreign country) MINNESOTA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JACK GRAY		14. MOTHER'S MAIDEN NAME NELLIE (WARNER) GRAY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 320-14-9565	
17. INFORMANT ST. AGNES HOSPITAL RECORDS		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypoxia (B) DUE TO, OR AS A CONSEQUENCE OF: pump's failure (C) Myo cardiac decompensation Subdural hemorrhage		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from APRIL 19 1971 to APRIL 20 1971 that (I) (we) last saw the deceased alive on APRIL 20 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE George Patrick MD		23B. DATE SIGNED 04/20/71	
23C. PHYSICIAN'S NAME (Type) GEORGE PATRICK MD		23D. ADDRESS BALTIMORE, MD 21229 ST. AGNES HOSPITAL; CATON & WILKENS AVES	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-23-71	
24C. NAME of CEMETERY or CREMATORY Lakewood Cem.		24D. LOCATION (City, town, or county) (State) Carroll Co. Ind.	
25A. DATE REC'D BY HEALTH DEPT. APR 26 1971		25B. NAME OF REGISTRAR R. E. F. R. R. R.	
25C. FUNERAL DIRECTOR J. C. C. C. C.		ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CITY HEALTH DEPARTMENT				REG. NO.	
H-520		71 4009		71 4009	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
HINES, Edward M.				4/20/71 11:00 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218				A. STATE Maryland	
				B. COUNTY	
C. CITY OR TOWN				D. INSIDE CITY LIMITS?	
Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER					
1323 Weldon Avenue					
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	7/4/15	55	USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired		water dept Balto City		Avoca, Pa.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
Michael J Hines				Mary Margaret Meade	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes 4/23/45-3/3/46		203-05-2070		VA Hospital Records 3900 L ch Raven Blvd., Balto., Md 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE LUNG ABCESS DUE TO, OR AS A CONSEQUENCE OF:					
(B) CARCINOMA OF THE LUNG DUE TO, OR AS A CONSEQUENCE OF:					
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from April 6th 19 71 to April 20th 19 71 that (I) (we) last saw the deceased alive on April 20th 19 71 and that in (I) (us) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Michael B Troner				4/21/71	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
MICHAEL B. TRONER, M.D.				3900 Loch Raven Boulevard Baltimore, Maryland 21218	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		4-23-1971		Cedar Hill Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 26 1971		Ritchie Hwy., Balto. Co. Md.		Howard H. Hubbard, 4107 Wilkens Ave. 21229	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH									
BIRTH NO. 71 4010					REG. NO. 71 4010				
1. NAME OF DECEASED (Type or Print) STEKELenburg, Cornelius					2. DATE AND HOUR OF DEATH 4/22/71 11:00 a. M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital					A. STATE Maryland B. COUNTY Anne Arundle 5200				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					C. CITY OR TOWN Glen Burnie		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
					E. STREET AND NUMBER 500 5th Avenue				
5. SEX Male	6. RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/16/16	9. AGE (In years last birthday) 54	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cheff			10B. KIND OF BUSINESS OR INDUSTRY KLM Air Lines		11. BIRTHPLACE (State or foreign country) Netherlands		12. CITIZEN OF WHAT COUNTRY? Holland		
13. FATHER'S NAME Cornelius Stekelenburg, Sr.					14. MOTHER'S MAIDEN NAME Gertrudis Bel				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 065 30 5008		17. INFORMANT Mrs. Gertrudis J. Stekelenburg (wife)				
18. CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Metastatic Oat Cell Carcinoma lung					4 months				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) _____ (C) _____									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION 4-19-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Intractable pain midline myelotomy			20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 4-17-71 19 71 to 4-22 19 71 that (I) (we) last saw the deceased alive on 4-17 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Donald W. Bryan					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 4-22-71	
23C. PHYSICIAN'S NAME (Type) Donald W. Bryan M.D.					23D. ADDRESS The Johns Hopkins Hospital				
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE Apr. 26/71		24C. NAME OF CEMETERY OR CREMATORY Fort Lincoln			24D. LOCATION (City, town, or county) (State) Wash. D.C.		
25A. DATE RECD BY HEALTH DEPT. APR 26 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.R.			25C. FUNERAL DIRECTOR Singleton Funeral Home			ADDRESS Glen Burnie, Maryland	

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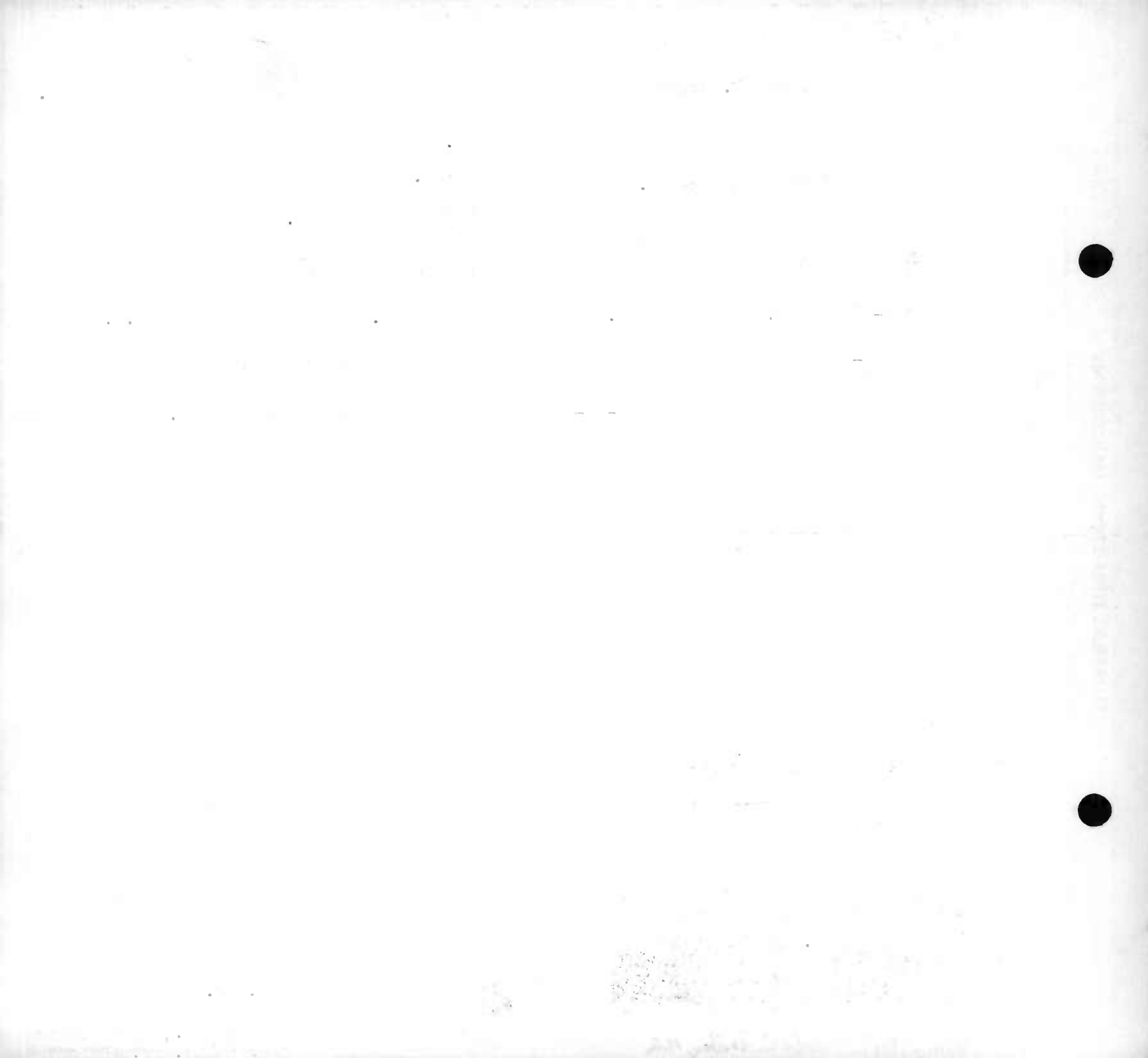
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

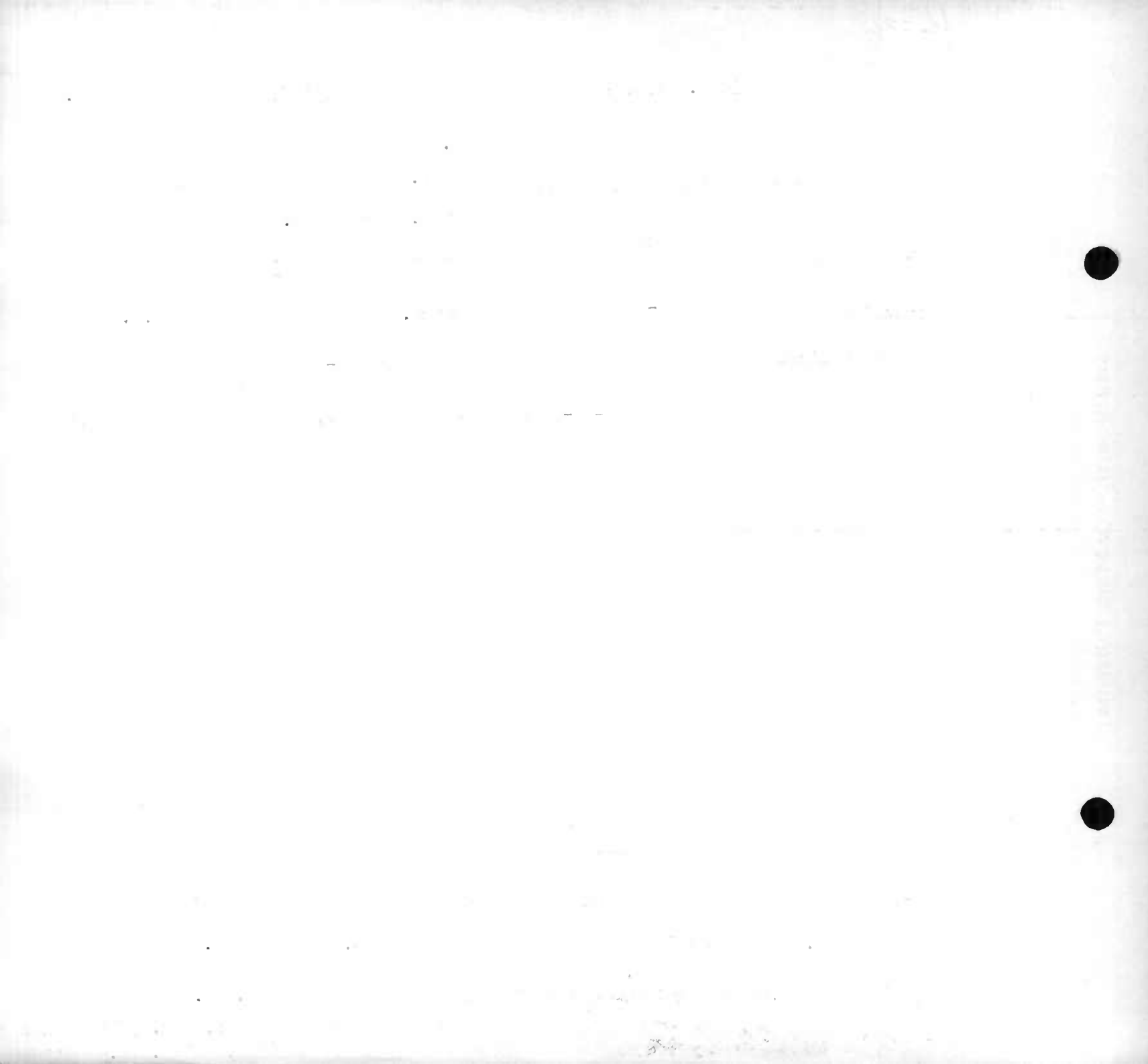
BALTIMORE CITY HEALTH DEPARTMENT									
C-635 71 4011					CERTIFICATE OF DEATH				
BIRTH NO.					REG. NO. 71 4011				
1. NAME OF DECEASED (Type or Print) James F. Courtney					2. DATE AND HOUR OF DEATH 4/20/71 7:30 A.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1631 Northwick Rd.					A. STATE Md. B. COUNTY 2759				
					C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
					E. STREET AND NUMBER 1631 Northwick Rd.				
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/3/99	9. AGE (In years last birthday) 71	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief-Fire Dept.				10B. KIND OF BUSINESS OR INDUSTRY Balto. City		11. BIRTHPLACE (State or foreign country) Balto.		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME -					14. MOTHER'S MAIDEN NAME Katherine Broderick				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 214-38-71145		17. INFORMANT ADDRESS Miss Ann Courtney, dghtr. same address			
18. 4/12/71 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiac ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Pulmonary embolism					2 yrs				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from March 7 19 68 to April 17 19 71 that (I) (we) last saw the deceased alive on April 17 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Romulo V. Goco A.D. DEGREE					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED April 21, 1971	
23C. PHYSICIAN'S NAME (Type) Dr. Romulo Goco DEGREE					23D. ADDRESS 5500 Bowleys Lane				
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 4/22/71		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Md.			
25A. DATE REC'D BY HEALTH DEPT. APR 26 1971			25B. NAME OF REGISTRAR 3331 E. Brehms		25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Homes, Inc., 3331 Brehms Lane, Balto. Md. 21215				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 4012		REG. NO. 71 4012	
CERTIFICATE OF DEATH							
BIRTH NO. <u>P-236</u>							
1. NAME OF DECEASED (Type or Print) <u>Bessie E. Pazderka</u>				2. DATE AND HOUR OF DEATH <u>4/19/71</u> <u>5 P.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 Johns Hopkins Hospital DOA</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>703</u>			
				C. CITY OR TOWN <u>Balto.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>720 N. Maderia St.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/21/07</u>	9. AGE (In years last birthday) <u>63</u>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Czech.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Frank Zicha</u>				14. MOTHER'S MAIDEN NAME <u>Frances -</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-10-1364</u>		17. INFORMANT <u>Frank Pazderka,</u>		ADDRESS <u>same as above</u>	
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>Coronary Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Arteriosclerotic C.V. Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>March 15</u> 19 <u>68</u> to <u>April 19</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>April 13</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Jason H. Gaskel MD</u>				23B. DATE SIGNED <u>April 21/1971</u>			
23C. PHYSICIAN'S NAME (Type) <u>Dr. Jason Gaskel</u>				23D. ADDRESS <u>637 S. Conkling St.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>4/23/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Sacred Heart of Jesus</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 26 1971</u>		25B. NAME OF REGISTRAR <u>Rebecca E. ...</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Homes, Inc.</u>		ADDRESS <u>3331 Brehms Lane, Balto. Md. 21213</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

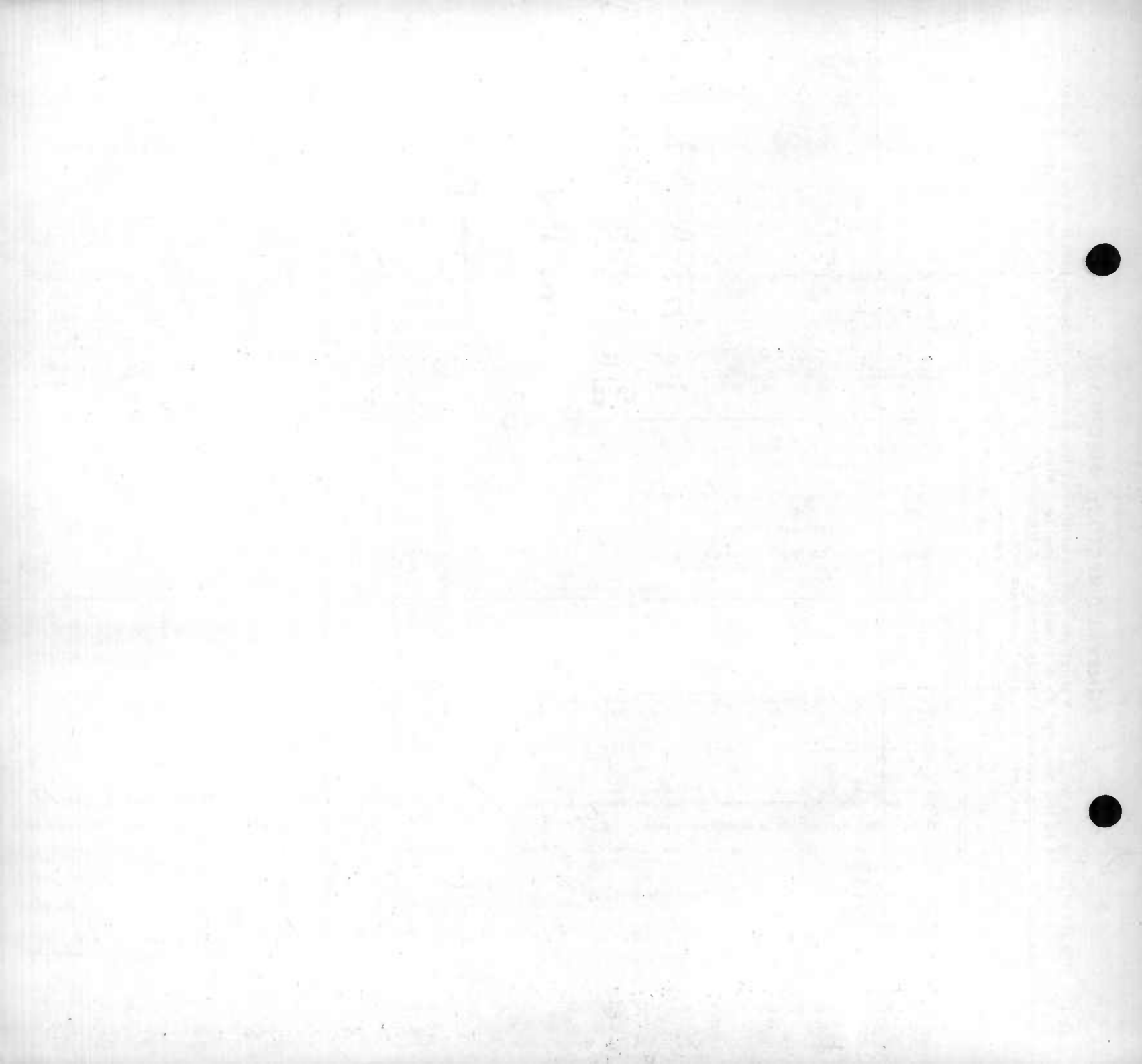
1-516		71 4013		BALTIMORE CITY HEALTH DEPARTMENT		71 4013	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <u>Lambros Louis P.</u>				2. DATE AND HOUR OF DEATH <u>April 22 1971</u> <u>1 55 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 University Hospital</u>				A. STATE <u>Maryland</u>		B. COUNTY <u>21229 2854</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>213 Mallow Hill Rd</u>			
5. SEX <u>Male</u>	6. RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/25/90</u>	9. AGE (in years last birthday) <u>80</u>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>RESTAURANT OWNER</u>		11. BIRTHPLACE (State or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>PANAKAKS LAMBRINOPOULOS</u>				14. MOTHER'S MAIDEN NAME <u>—</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-05-4232</u>		17. INFORMANT <u>HOST. RECORDS</u>		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Bronchogenic Carcinoma</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Bronchogenic Carcinoma</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>3/5</u> 19 <u>71</u> to <u>4/22</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>April 22</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Lawrence Kelly Jr. MD</u>				23B. DATE SIGNED <u>4/22/71</u>			
23C. PHYSICIAN'S NAME (Type) <u>DEGREE</u>				23D. ADDRESS <u>University Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4/24/71</u>		24C. NAME of CEMETERY or CREMATORY <u>GREEK CEMETERY</u>		24D. LOCATION (City, town, or county) (State) <u>WINSOR MILL RD BALTO. CO.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 26 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Kelly, MD</u>		25C. FUNERAL DIRECTOR <u>21228</u>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

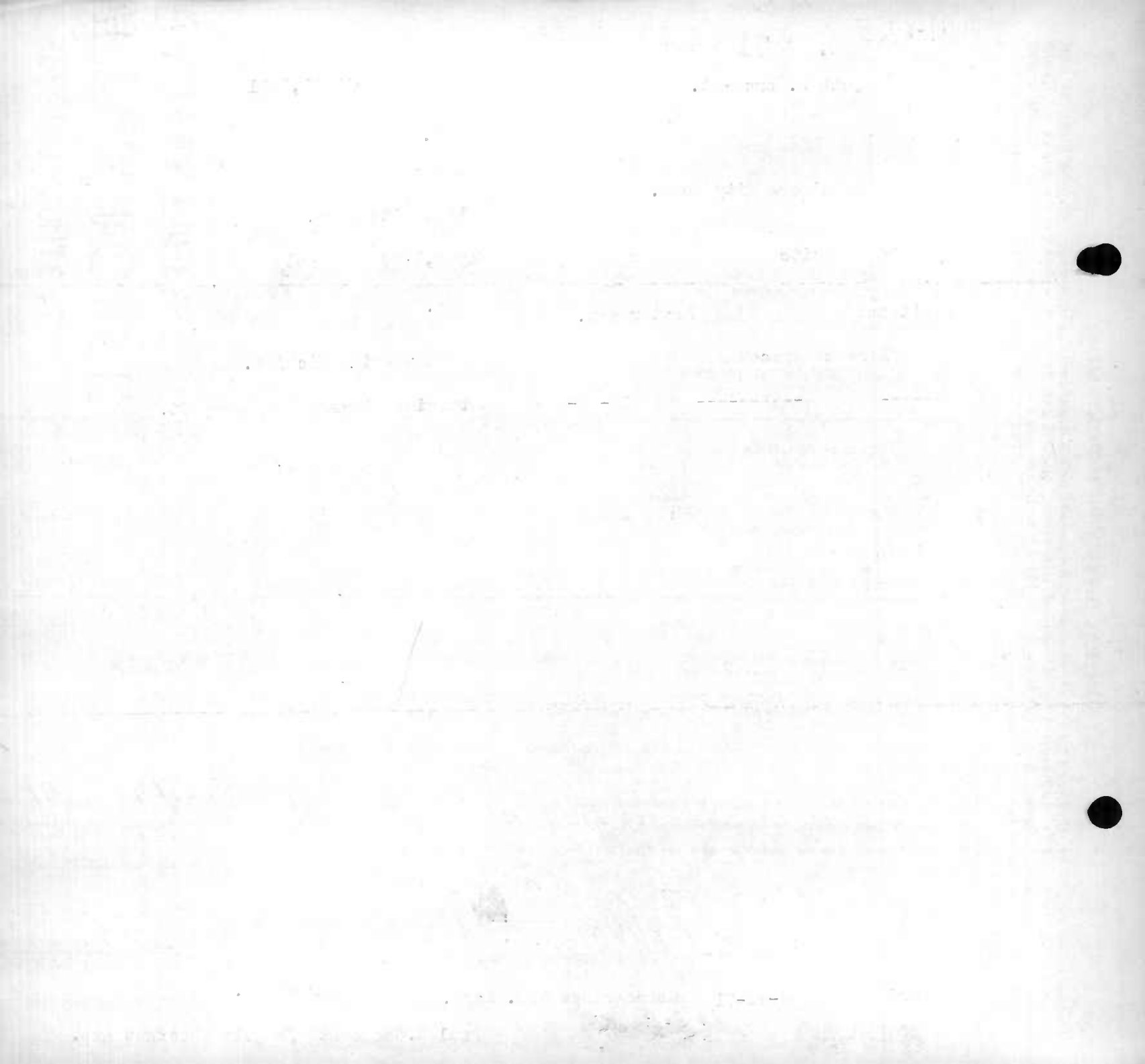
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4014	
<div style="display: flex; justify-content: space-between;"> S-320 71 4014 </div> <div style="display: flex; justify-content: space-between;"> BIRTH NO. CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) Stocks Velma June			2. DATE AND HOUR OF DEATH 4/22/71 3⁴⁰ a.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION HARFORD GARDENS CONV. HOME			A. STATE MD. B. COUNTY Balti.		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 6520 ST. HELENA AVE. #22		
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-5-24	9. AGE (In years last birthday) 49	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HUSB.		10B. KIND OF BUSINESS OR INDUSTRY -	11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME DAVID AMOS			14. MOTHER'S MAIDEN NAME JAKAH J. STEWART		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-22-990	17. INFORMANT ELBERT L. STOCKS, 6520 ST. HELENA AVE		ADDRESS 21222
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma of Larynx			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year +		
18. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <div style="text-align: center;">II</div> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from April 13 1971 to April 22 1971 , that (I) (we) last saw the deceased alive on April 22 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death.					
23A. SIGNATURE Lois M. Zimmerman M.D.			23B. DATE SIGNED 4/22/71		23C. PHYSICIAN'S NAME (Type) Lois M. Zimmerman M.D.
23D. ADDRESS 3202 Harford Rd. Baltimore, Md.			24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		
24B. DATE 24 APR 71			24C. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH		24D. LOCATION (City, town, or county) (State) BALTO. CO., MD.
25A. DATE REC'D BY HEALTH DEPT. APR 26 1971		25B. NAME OF REGISTRAR Ruth E. Fisher, R.D.		25C. FUNERAL DIRECTOR ULRICHA FOWLER HOUSE DUNDALK, MD.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										
BIRTH NO. M-625					REG. NO. 71 4015					
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH					
Ruth N. Merchant.					April 21, 1971					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hosp.					A. STATE Md. B. COUNTY Baltimore					
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					C. CITY OR TOWN Dundalk D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
E. STREET AND NUMBER 1526 Rita Road.										
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 9, 1909		9. AGE (In years last birthday) 61		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress			10B. KIND OF BUSINESS OR INDUSTRY Resteraunt.			11. BIRTHPLACE (State or foreign country) Md.			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Clarence Tracey					14. MOTHER'S MAIDEN NAME Catherine Wickins.					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -----					16. SOCIAL SECURITY NO. 213-09-8046		17. INFORMANT Catherine Kingery 705 Berry St.			ADDRESS
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Coronary Occlusion ASCVD					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes 10 years					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (A)										
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from Jun 10 1951 to April 21 1971 , that (I) (we) last saw the deceased alive on April 18 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE L. WALLENSTEIN M.D.					23B. DATE SIGNED					
23C. PHYSICIAN'S NAME (Type) Leonard Wallenstein					23D. ADDRESS 848 W 36th St					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 4-26-71			24C. NAME OF CEMETERY or CREMATORY Meadowridge Mem. Park.			24D. LOCATION (City, town, or county) (State) Dorsey Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 26 1971					25B. NAME OF REGISTRAR Paul E. Chenoweth Jr			25C. FUNERAL DIRECTOR Paul E. Chenoweth Jr 3615 Chestnut Ave.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-620 71 4016				BALTIMORE CITY HEALTH DEPARTMENT		71 4016	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
BOWERS, MICHAEL JAY				4-22-71 8:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE B. COUNTY			
ST AGNES HOSPITAL WILKENS & CATON AVES.-BALTO., MD.				MD. 2531			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER							
				502 COVENTRY RD-BALTO., MD. 21229			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH	
MALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10 25 52	
						18 YRS	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
NONE						MARYLAND	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
FRANKLIN BOWERS				VADNA (PARKS)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
NO				215-60-5857		BALTO. MD. ST AGNES HOSPITAL-WILKENS & CATON AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: hypoxia			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: pulmonary edema, meningitis			
				(C) Chronic pyelonephritis 2° to congenital			
				Udder vech obstruction			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
KAS				YES.			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (A) (this hospital) attended the deceased from 4 22 19 71 to 4 22 19 71 that (B) (we) last saw the deceased alive on 4 22 19 71 and that (C) (we) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
George Patrick M.D.				4-23-71			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
George Patrick M.D.				ST AGNES HOSPITAL., BALTO., MD. 21229			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		4-26-1971		Mt. Olivet Cemetery		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
APR 26 1971		Robert E. Fisher M.D.		Howard H. Hubbard,		4107 Wilkens Ave. 21229	

[illegible]

FUNERAL DIRECTOR: IMPORTANT

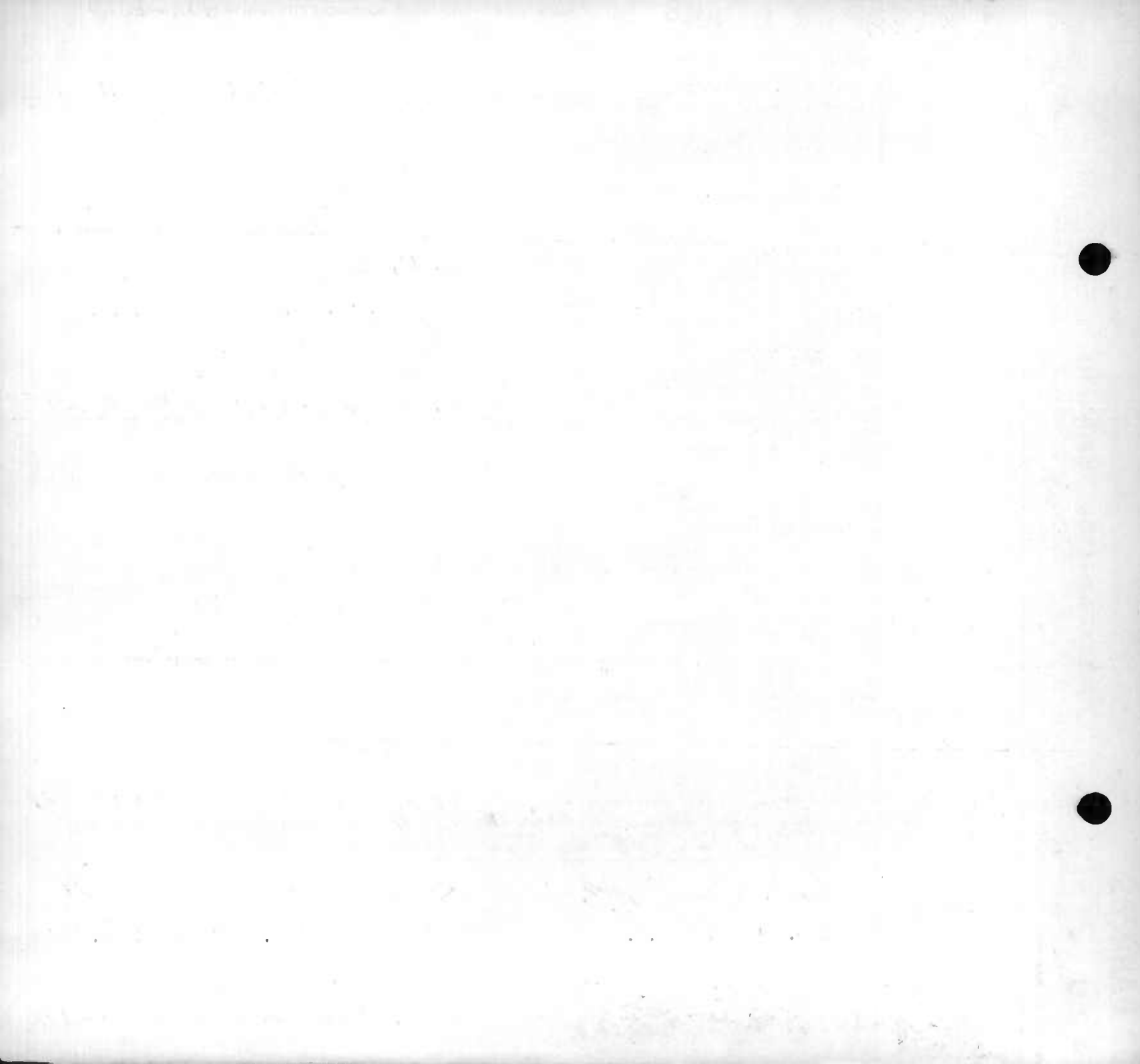
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 4017	
L-550 71 4017 BIRTH NO.		1. NAME OF DECEASED (Type or Print) Florence Lehman			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH 4/22/71 11:50 A.M.			
FULL NAME OF HOSPITAL OR INSTITUTION S. BALT Gen'l Hosp		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 2404			
5. SEX F		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 1-30-24 9. AGE (In years last birthday) 47	
13. FATHER'S NAME James Simmons		14. MOTHER'S MAIDEN NAME Florence Lehman		11. BIRTHPLACE (State or foreign country) MD	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-18-9092		17. INFORMANT ADDRESS CHART	
18. 4/22/71 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) SMALL BOWEL INFARCTION		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 hrs - 2-3 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19A. DATE OF OPERATION 4/22/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED MES. INFARCT		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that at (this hospital) attended the deceased from 4/22/71 19 4/22 19 71 that he (we) last saw the deceased alive on 4/22/71 19 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Neil Novin				23B. DATE SIGNED 4/22/71	
23C. PHYSICIAN'S NAME (Type) Neil Novin MD				23D. ADDRESS 3001 So Hanover St	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/26/71		24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem	
25A. DATE REC'D BY HEALTH DEPT. APR 26 1971		25B. NAME OF REGISTRAR J. E. Kelly		25C. FUNERAL DIRECTOR ADDRESS 130 E. Fort Ave	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

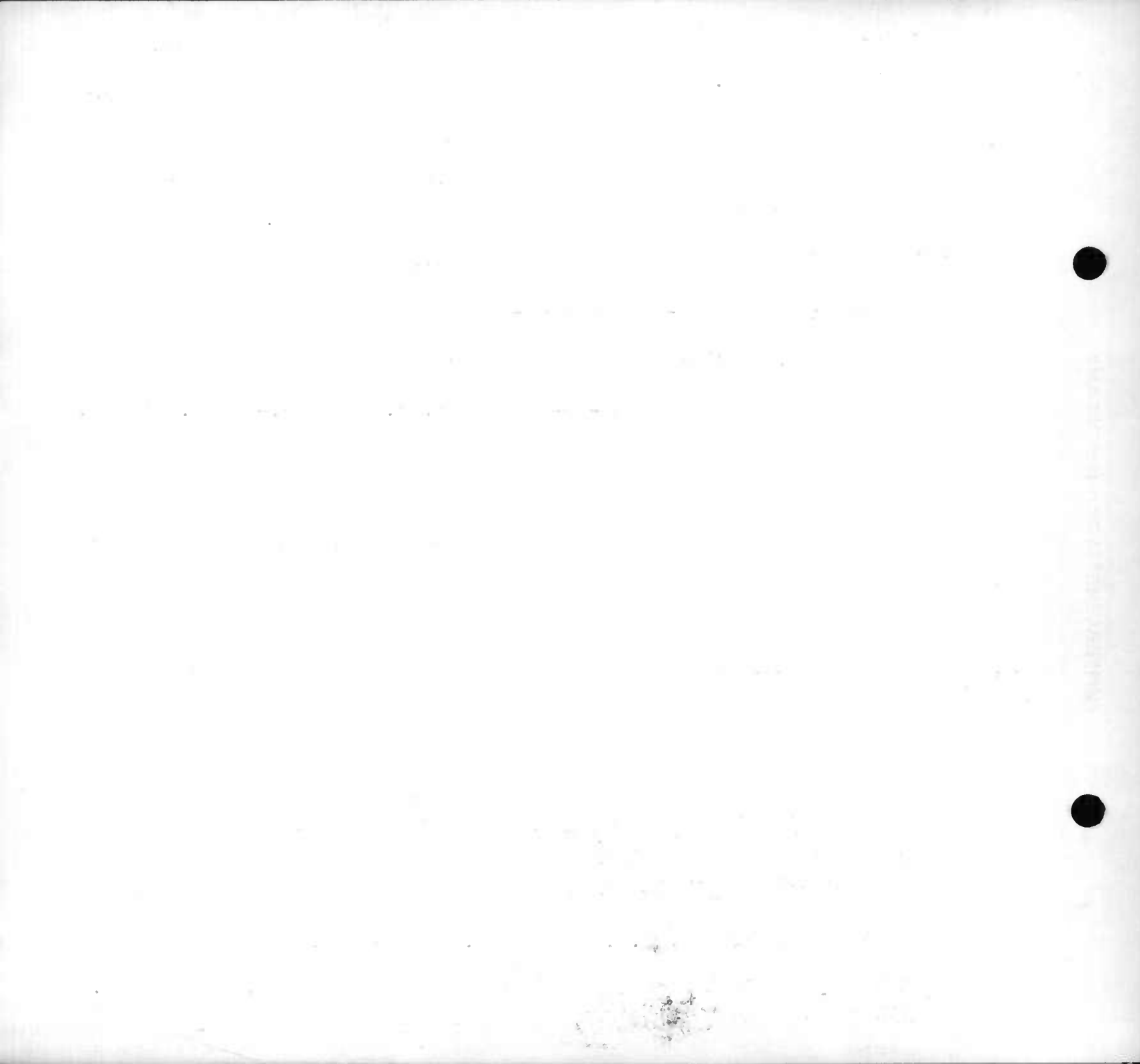
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
<div style="font-size: 2em; font-weight: bold;">S-160</div> <div style="font-size: 1.5em; font-weight: bold;">71 4018</div>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Anna B. Schafer</i>			2. DATE AND HOUR OF DEATH <i>April 21, 1971 8:15 P.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, If institution: residence, before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>003800 Taylore Avenue</i>			A. STATE <i>Maryland</i> B. COUNTY <i>2735</i>		
			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <i>3800 Taylore Avenue</i>		
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 11, 1887</i>	9. AGE (In years lost birthday) <i>83</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Florist</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Self-Employed</i>		11. BIRTHPLACE (State or foreign country) <i>Balto. Co. Md.</i>	
13. FATHER'S NAME <i>Frederick Decker</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Mary V. Conti</i>
					ADDRESS <i>-3800 Taylore Ave.-21236</i>
18. <i>7/2/4</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Circulatory failure</i> (B) <i>Arteriosclerotic Cardiovascular disease</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1963</i> 19 <i>to April 21</i> 19 <i>71</i> , that (I) (we) last saw the deceased alive on <i>April 21</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>John C. Miller</i>				23B. DATE SIGNED <i>April 22 71</i>	
23C. PHYSICIAN'S NAME (Type) <i>Samuel I. O'Mansky M.D.</i>				23D. ADDRESS <i>8523 Loch Raven Blvd. Baltimore, Md. 21204</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4-24-71</i>		24C. NAME OF CEMETERY or CREMATORY <i>Parkwood Cemetery</i>	
				24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 26 1971</i>		25B. NAME OF REGISTRAR <i>John C. Miller</i>		25C. FUNERAL DIRECTOR <i>John C. Miller Inc-6415 Belair Road-21206</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-300		71 4019		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 4019	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print) Mary E. White				2. DATE AND HOUR OF DEATH 4/23/71 2:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 904 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2924 Independence St.			
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/13/09	9. AGE (In years last birthday) 61	10. If Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Andrew J. Doerflian				14. MOTHER'S MAIDEN NAME Nellie O'Connor			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-09-1344		17. INFORMANT ADDRESS Chas. J. White Jr. - 912 E. 30th St.			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIOGENIC SHOCK MYOCARDIAL INFARCTION		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HRS DAYS	
19A. DATE OF OPERATION 4/23/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indefinite medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/23/71 to 4/23/71 that (I) (we) last saw the deceased alive on 4/23/71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Susan Bollinger, M.D.				23B. DATE SIGNED 4/23/71		23C. PHYSICIAN'S NAME (Type) N. Calvert St.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/27/71		24C. NAME OF CEMETERY OR CREMATORY Gardens of Faith		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 26 1971		25B. NAME OF REGISTRAR J. E. Taylor, Jr.		25C. FUNERAL DIRECTOR ADDRESS Donovan Funeral Home - 3818 Roland Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X REG. NO. <u>71 4020</u>	
0-416 BIRTH NO.		71 4020		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) SARAH E. OLIVER			2. DATE AND HOUR OF DEATH April 21, 1971 5:45 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1749 South Hanover St.			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY ALLEGANY C. CITY OR TOWN CUMBERLAND D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 146 POIK STREET		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 25, 1904	9. AGE (In years last birthday) 66	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JACOB W. WHITACRE			14. MOTHER'S MAIDEN NAME EMILY SEATON		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-05-4869	17. INFORMANT (DAUGHTER) MRS LEONA BECKNER 1749 S. HANOVER ST BALTIMORE		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Cerebral Thrombosis ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. metastatic carcinoma Fracture left hip Pathologic, carcinoma			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 4 months 2 years		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Hemiplegia					
19A. DATE OF OPERATION Dec 1970		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Hernia repair		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2-17 19 71 to 4/21 19 71 that (I) (we) lost saw the deceased alive on 4/20 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John P. Urlock Jr			23B. DATE SIGNED 4/21/71		
23C. PHYSICIAN'S NAME (Type) John P. Urlock Jr M.D.			23D. ADDRESS 1227 Washington Blvd. Baltimore, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE APRIL 26, 1971		24C. NAME OF CEMETERY or CREMATORY MT. SAVAGE METHODIST CEMT. MT. SAVAGE ALLEGANY MD.	
25A. DATE REC'D BY HEALTH DEPT. APR 26 1971		25B. NAME OF REGISTRAR John P. Urlock Jr		25C. FUNERAL DIRECTOR SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MD	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 71 4021	
<div style="display: flex; justify-content: space-between;"> 8-530 71 4021 </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) RUBY SMITH		2. DATE AND HOUR OF DEATH 4/23/71 8:09pm. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL 33		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MARYLAND B. COUNTY	
		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1323 E. BIDDLE STREET			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/27/08	9. AGE (in years last birthday) 62	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wilsonville, Ala.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME PLES CLEVELAND		14. MOTHER'S MAIDEN NAME LORRAINE MC ADAMS	
15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 420 24 9465A		17. INFORMANT ADDRESS Jerry Smith 1323 E. Biddle St.	
18. 13401 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Scleroderma Pulmonary disease		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (if in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/23 19 71 to 4/23 19 71 that (I) (we) last saw the deceased alive on 4/23 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>David Driscoll MD</i>				23B. DATE SIGNED 4/23/71	
23C. PHYSICIAN'S NAME (Type) DR. DAVID DRISCOLL		23D. ADDRESS JOHN HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-28-71		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. APR 26 1971		25B. NAME OF REGISTRAR <i>Robert E. Taylor, Jr.</i>		25C. FUNERAL DIRECTOR 1735 Harford Ave. ADDRESS 3 Marshall W. Jones, Jr.	

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JOHN HOPKINS HOSPITAL

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JOHN HOPKINS HOSPITAL

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JOHN HOPKINS HOSPITAL

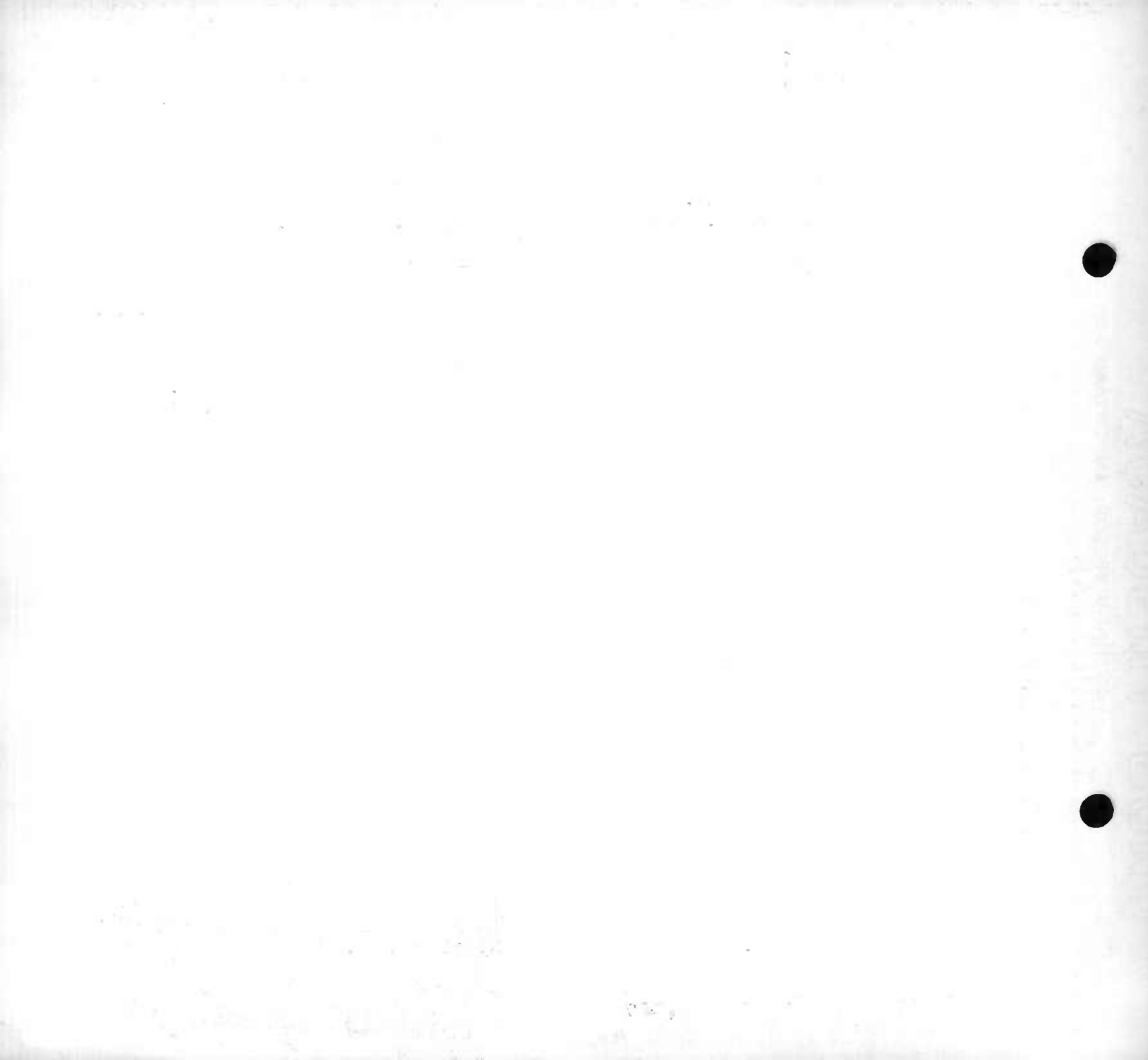
JOHN HOPKINS HOSPITAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-526 71 4022		BALTIMORE CITY HEALTH DEPARTMENT		71 4022	
BIRTH NO. 71-06434		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) Jones, Boy Vette			2. DATE AND HOUR OF DEATH 4-17-71 4:25 P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE Maryland		
31 Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224			B. COUNTY 1502		
5. SEX Male			6. RACE Negro		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 4-13-71		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			9. AGE (in years last birthday) 4		
10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Maryland		
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			14. MOTHER'S MAIDEN NAME Yvette Predisa Jones		
16. SOCIAL SECURITY NO.			17. INFORMANT 4940 Eastern Ave. ADDRESS BCH Records: Baltimore, Md. 21224		
18. 776.21 CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			RESPIRATORY DISTRESS SYNDROME		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			(B) PREMATURITY		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) Yes			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 4/13/71 1971 to 4/17/71 1971 that (We) last saw the deceased alive on 4/17/71 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Peter R. Holbrook MD DEGREE			23B. DATE SIGNED 4/17/71		
23C. PHYSICIAN'S NAME (Type) Peter R. Holbrook			23D. ADDRESS Baltimore City Hospitals Baltimore, Md. 21224		
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation			24B. DATE 4-19-71		
24C. NAME OF CEMETERY OR CREMATORY Baltimore City Hospitals			24D. LOCATION Baltimore, Md. 21224		
25A. DATE REC'D BY HEALTH DEPT. APR 26 1971			25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		
25C. FUNERAL HOME ADDRESS			25D. ADDRESS		

HOSPITAL DISPOSAL



D-553 71 4023		BALTIMORE CITY HEALTH DEPARTMENT		71 4023	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) Robert R. Diamond			2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year Hour 3 22 71 1:30 a.m.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 35 Church Home			3. DATE PRONOUNCED DEAD Month Day Year Hour 3 22 71 1:30 a.m.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 104
6. SEX male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years last birthday) 66	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
19. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			Arteriosclerotic cardiovascular disease		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			Chronic emphysema of lungs		
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes (partial)	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Peter Lipkovic</i> M.D. DATE SIGNED 3/22/71 EXAMINER'S NAME (Type) Peter Lipkovic, M.D. ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4-22-71		24C. NAME OF CEMETERY or CREMATORIUM (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. APR 26 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. TO BE FILLED IN BY DIRECTOR ADDRESS	

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCHD

1982 17

WALTON & POLYMER

UNITED STATES OF AMERICA
DEPARTMENT OF AGRICULTURE
NATIONAL ACADEMY OF SCIENCES
NATIONAL RESEARCH COUNCIL ON AGRICULTURE
NATIONAL RESEARCH COUNCIL ON HUMANITIES
NATIONAL RESEARCH COUNCIL ON NATURAL SCIENCES
NATIONAL RESEARCH COUNCIL ON PHYSICAL SCIENCES
NATIONAL RESEARCH COUNCIL ON SOCIAL SCIENCES
NATIONAL RESEARCH COUNCIL ON THE ENVIRONMENT AND DEVELOPMENT
NATIONAL RESEARCH COUNCIL ON THE HUMANITIES
NATIONAL RESEARCH COUNCIL ON THE NATURAL SCIENCES
NATIONAL RESEARCH COUNCIL ON THE PHYSICAL SCIENCES
NATIONAL RESEARCH COUNCIL ON THE SOCIAL SCIENCES
NATIONAL RESEARCH COUNCIL ON THE ENVIRONMENT AND DEVELOPMENT

P-146

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 4024

1. NAME OF DECEASED (Type or Print) Theodore S Poplar		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1758 Bank St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 24 71 4:15 p M.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 202	
9. DATE OF BIRTH June 1, 1914		10. AGE (in years last birthday) 56	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Poplar		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
15. MOTHER'S MAIDEN NAME Victoria		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO.		18. INFORMANT Joseph Poplar	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) partial		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Partial Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE [Signature] M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/25/71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-28-1971	
24C. NAME OF CEMETERY or CREMATORY Holy Rosary		24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 26 1971		25B. NAME OF REGISTRAR [Signature]	
25C. FUNERAL DIRECTOR Lilly & Zeiler Inc.		ADDRESS 1901-07 Eastern Ave.	

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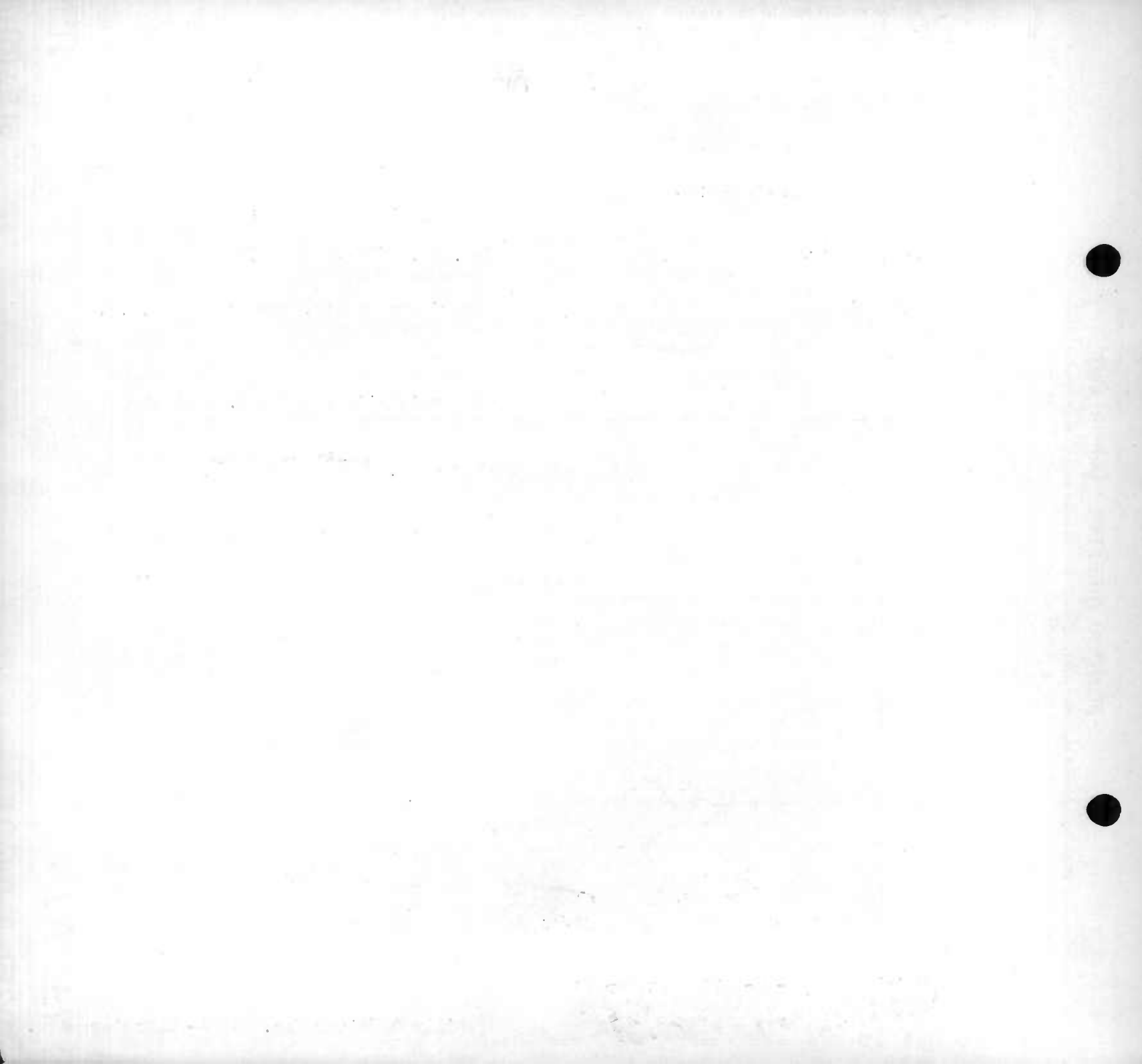
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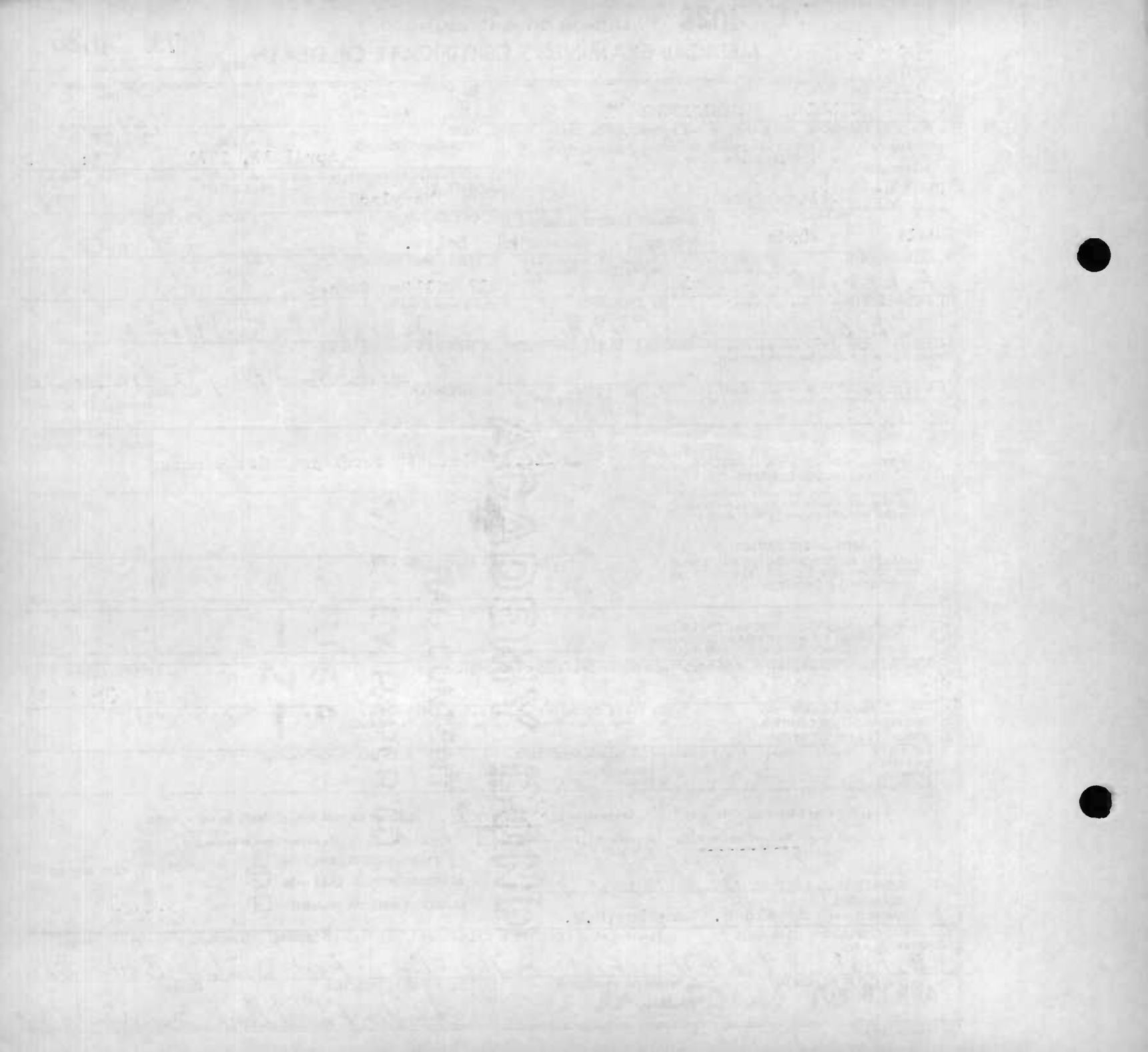
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																			
71 4025 CERTIFICATE OF DEATH																			
REG. NO. 71 4025																			
BIRTH NO. D-200					1. NAME OF DECEASED (Type or Print) EMMA DOVIS					2. DATE AND HOUR OF DEATH 4/23/71 6³⁰ A M.									
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Gould Convalesarium										4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 103									
										C. CITY OR TOWN Baltimore									
										D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>									
										E. STREET AND NUMBER 2421 Fleet Street									
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 30, 1885		9. AGE (In years last birthday) 85		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10B. KIND OF BUSINESS OR INDUSTRY Own Home					11. BIRTHPLACE (State or foreign country) Baltimore County, Maryland									
12. CITIZEN OF WHAT COUNTRY? U.S.A.					13. FATHER'S NAME Wentzel					14. MOTHER'S MAIDEN NAME									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO.					17. INFORMANT Mrs Mamie Miller									
										ADDRESS 615 S. Port Street									
18. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Recurrent Pneumonia										CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic Congestive Heart Failure					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic Cardiovascular Disease										(B) DUE TO, OR AS A CONSEQUENCE OF: Chronic Brain Syndrome, Decubitus Ulcer, Aspiration					(C) months years				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Chronic Brain Syndrome, Decubitus Ulcer, Aspiration																			
19A. DATE OF OPERATION 0					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) No					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from 3/1/71 to 4/23/71 , that (I) (we) last saw the deceased alive on 4/21/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE Albert B. Bradley										Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED 4/23/71				
23C. PHYSICIAN'S NAME (Type)										23D. ADDRESS									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 4-26-1971					24C. NAME of CEMETERY or CREMATORY Cedar Hill					24D. LOCATION (City, town, or county) (State) Anne Arundel, Maryland				
25A. DATE REC'D BY HEALTH DEPT.					25B. NAME OF REGISTRAR					25C. FUNERAL DIRECTOR Lilly & Zeiler Inc.					ADDRESS 1901-08 Eastern Ave.				



71 4026		BALTIMORE CITY HEALTH DEPARTMENT		71 4026	
S-451		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO.	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD	
WILLIAM SWELLENBURGER		Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
00817 William Street		Maryland		2201	
6. SEX Male		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
9. DATE OF BIRTH Feb 13 1908		10. AGE (In years last birthday) 65		11. BIRTHPLACE (State or foreign country) Ohio	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Joseph F Swellenberger		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME Mary Ellenberger		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT ADDRESS		19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Arteriosclerotic cardiovascular disease			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes (Partial)	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		24. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
APR 26 1971		Fiet - Baltic Ohio		Fiet Cemetery, Baltic Ohio	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 26 1971		R. E. Taylor, M.D.		Lingler Funeral Home Sugar Creek, Ohio	



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71 4027

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 71 4027

REG. NO. 71 4027

1. NAME OF DECEASED (Type or Print) Otis SAMUEL Dailey

2. DATE OF DEATH Known ☐ Month Day Year Hour M. Estimated ☐ M.

3. DATE PRONOUNCED DEAD Month Day Year Hour April 22, 1971 5:25 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) PROVIDENT HOSPITAL (DOA)

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1502

6. SEX Male 7. RACE Negro 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES ☒ NO ☐

9. DATE OF BIRTH 10-11-1902 10. AGE (In years last birthday) 68 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min. E. STREET AND NUMBER 1811 N. Fulton Avenue

11. BIRTHPLACE (State or foreign country) A.R. COMD 12. CITIZEN OF USA 13. FATHER'S NAME NATHAN Dailey

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOR LABORER 14B. KIND OF BUSINESS OR INDUSTRY BOOK SUPPLIES 15. MOTHER'S MAIDEN NAME MARY NICHOLSON

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no 17. SOCIAL SECURITY NO. Alvora Dailey 1811 N. Fulton Ave

18. INFORMANT ADDRESS Alvora Dailey 1811 N. Fulton Ave

19. 412.4 CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) no

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 22F. HOW DID INJURY OCCUR?

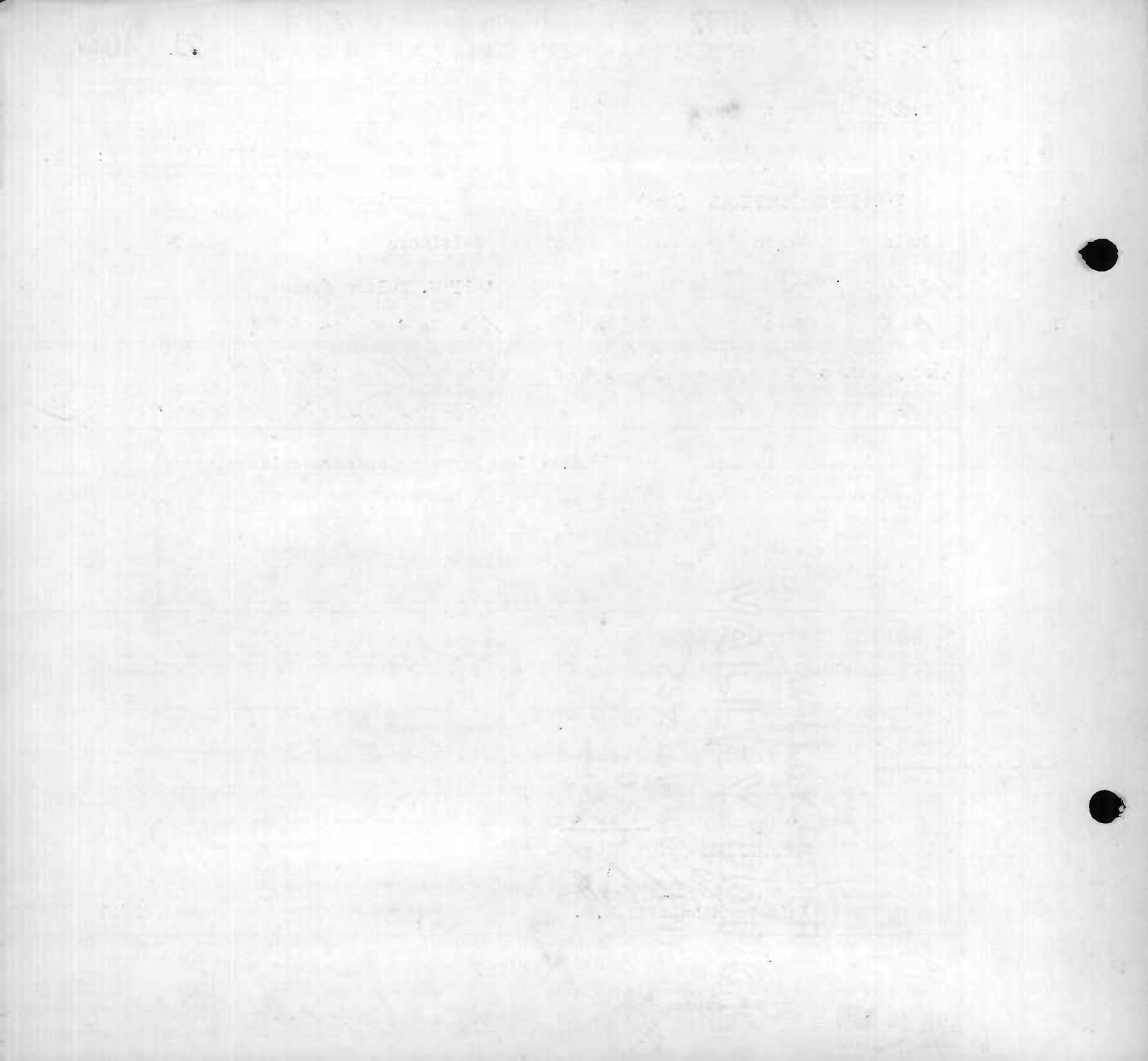
23. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Isidore Mihalakis, M.D. M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ DATE SIGNED 4/23/71 ASSOCIATE MEDICAL EXAMINER ☐

24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 4/27/71 24C. NAME OF CEMETERY or CREMATORY MT AUBURN 24D. LOCATION (City, town, or county) (State) Baltimore

25A. DATE REC'D BY HEALTH DEPT. APR 26 1971 25B. NAME OF REGISTRAR Robert E. Fisher, M.D. 25C. FUNERAL DIRECTOR Bourbarn & Day 635 914 pm ADDRESS St

VS 151-REV. 1/1/68



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 4028</u>	
W-252 <u>71 4028</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Antoni (Andy) J. Wisniewski</u>		2. DATE AND HOUR OF DEATH <u>4-22-71</u> <u>7:20 P.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>1446 Decatur Street</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>MD.</u> B. COUNTY <u>2401</u>	
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>1446 Decatur Street</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-31-1891</u>	9. AGE (In years lost birthday) <u>79</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Longshore man</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Poland</u>		13. FATHER'S NAME <u>Unknown</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>217-07-0396</u>		17. INFORMANT ADDRESS <u>MRS. Mary Wisniewski (wife): same</u>			
18. <u>531.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <u>Gastric ulcer</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>1+ yr.</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Adenocarcinoma of sigmoid colon</u>		<u>1+ yr.</u>			
19A. DATE OF OPERATION <u>12-22-70</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>II</u>		20A. AUTOPSY? (Yes or No) <u>no</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>—</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>no</u>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>Feb. 9 - 1970</u> to <u>4-22-1971</u> , that (I) (we) last saw the deceased alive on <u>4-19-1971</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>C. C. Chiu M.D.</u>		23B. DATE SIGNED <u>4-22-71</u>		23C. PHYSICIAN'S NAME (Type) <u>C. C. CHIU M.D.</u>	
23D. ADDRESS <u>1 E. Randall Street, Baltimore Md. 21230</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>4/26/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Cross Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 26 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Ave.</u>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4029	
BIRTH NO. 71 4029		SATCHELL		BALTIMORE CITY HEALTH DEPARTMENT	
1. NAME OF DECEASED (Type or Print) VICTOR H. SATCHELL		2. DATE AND HOUR OF DEATH 4/19/71 6:45 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Md General Hospital		A. STATE Md		B. COUNTY	
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 305 McMechen St.			
5. SEX Male	6. RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 28, 1933	9. AGE (In years last birthday) 38	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10B. KIND OF BUSINESS OR INDUSTRY Paint Factory		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Mellic Satchell		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes May 26, 1952 May 22, 1956		16. SOCIAL SECURITY NO. 211-30-837		17. INFORMANT Mr. Arthur Satchell 2911 Norfolk Ave	
18. 03891		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac Arrest		3 days	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: Sepsis			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Liver cirrhosis					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 4/12 1971 to 4/19 1971 that (we) last saw the deceased alive on 4/19 1971 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE M. Parado		23B. DATE SIGNED 4/19/71		23C. PHYSICIAN'S NAME (Type) JUAN M. PARADO MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-23-71		24C. NAME OF CEMETERY OR CREMATORY Mt Auburn Cem	
24D. LOCATION Westport		24E. LOCATION (City, town, or county) Md		24F. LOCATION (State) Md	
25A. DATE REC'D BY HEALTH DEPT. APR 26 1971		25B. NAME OF REGISTRAR J. E. Taylor, Jr.		25C. FUNERAL DIRECTOR J. E. Taylor, Jr.	
25D. ADDRESS 2222-14		25E. ADDRESS 2222-14		25F. ADDRESS 2222-14	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

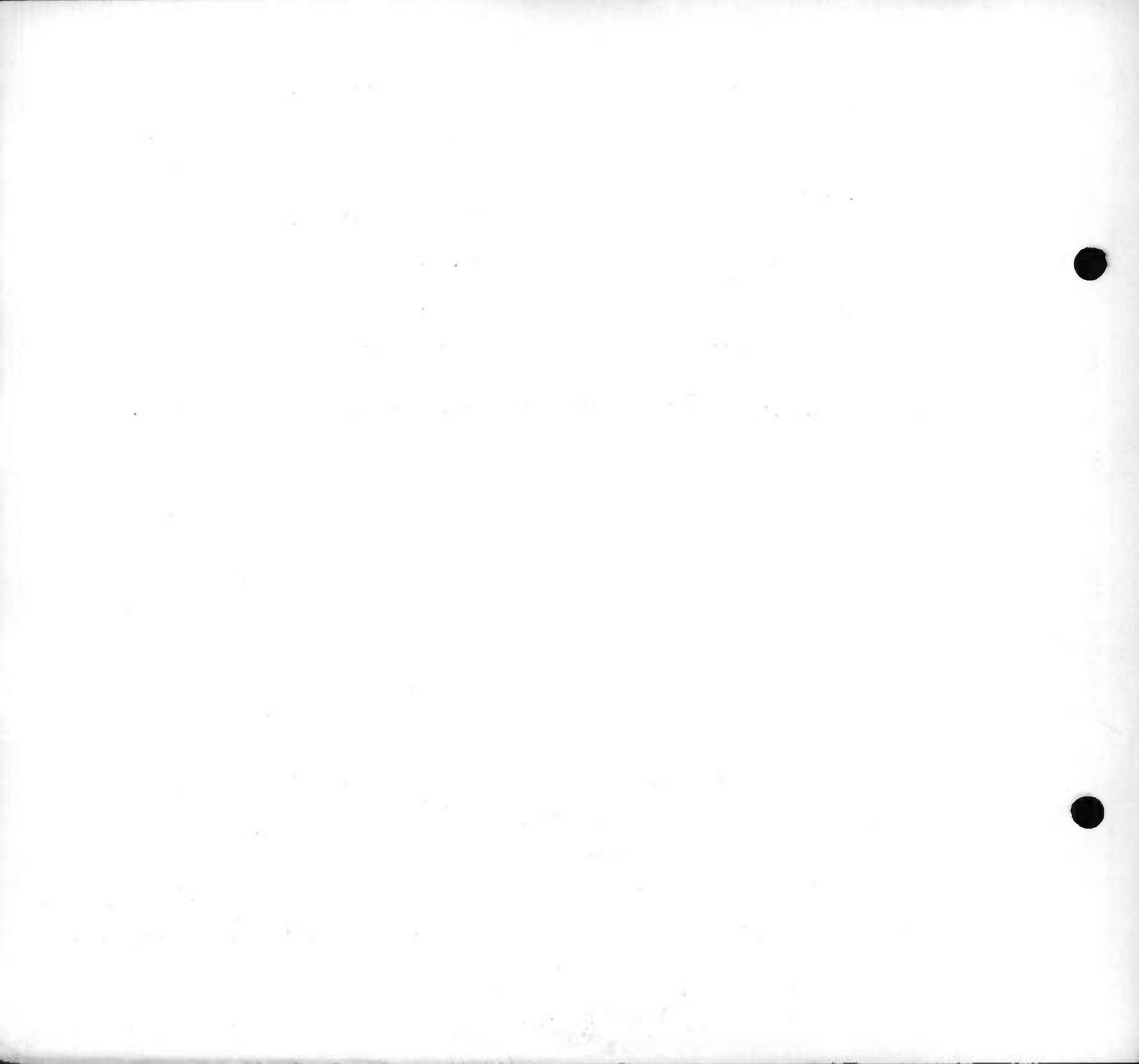
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71 4030

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 71 4030

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Chester Eason		2. DATE AND HOUR OF DEATH April 20, 1971	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 2798 1/2 W. North Avenue		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1506		C. CITY OR TOWN Baltimore	
5. SEX Male		6. RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Oct. 7, 1919		9. AGE (In years last birthday) 51		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Copper Burner		10B. KIND OF BUSINESS OR INDUSTRY Copper		11. BIRTHPLACE (State or foreign country) Gates, North Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Miles Eason		14. MOTHER'S MAIDEN NAME Mary Howard	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes Apr. 20, '42 Sep 20, '45		16. SOCIAL SECURITY NO. 240-24-3538		17. INFORMANT Mrs. Mary Eason 2816 Walbrook St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Bronchitis		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: pneumonia (B) DUE TO, OR AS A CONSEQUENCE OF: asoc. pneumonia (C) Suppured		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 mos.	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION N/A		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? N/A		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) N/A		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) N/A	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) N/A		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) N/A		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? N/A		22. I certify that (I) (this hospital) attended the deceased from 4/15/71 to 4/20/71 19__ that (I) (we) last saw the deceased alive on 4/18/71 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Uthman Ray Jr. M.D.		23B. DATE SIGNED 21 Apr 71		23C. PHYSICIAN'S NAME (Type) UTHMAN RAY JR. M.D.	
23D. ADDRESS 2225 W. North Ave 21216		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-25-71	
24C. NAME OF CEMETERY OR CREMATORY Greenwood		24D. LOCATION (City, town, or county) (State) NC		25A. DATE REC'D BY HEALTH DEPT. APR 26 1971	
25B. NAME OF REGISTRAR Robert E. Fabe, Jr.		25C. FUNERAL DIRECTOR Joseph P. Ricks		25D. ADDRESS 2222 W. North Ave	



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71 4031

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 4031

BIRTH NO.		1. NAME OF DECEASED (Type or Print) HENRY KINARD		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 35 CHURCH HOME AND HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour April 24, 1971 2:30 A. M.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 708	
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH March 25, 1934		10. AGE (In years last birthday) 37		E. STREET AND NUMBER 643 Gutman Avenue	
11. BIRTHPLACE (State or foreign country) Clinton S. C.		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Ernest Kinard	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Lorena Howard	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.		18. INFORMANT Lorenna Blizzard 2569 Cedar Ave	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Stab wound of chest		CAUSE OF DEATH Stab wound of chest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 22D. TIME OF INJURY (APPROX.) 4-24-71 1:30 A. m.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) In front of 125 Colvin Street 501	
		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Stabbed by unknown assailant	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/24/71					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE April 28/71		24C. NAME OF CEMETERY or CREMATORY Grubbs New Park	
24D. LOCATION (City, town, or county) (State) Arbutus Md.		25A. DATE REC'D BY HEALTH DEPT. APR 26 1971		25B. NAME OF REGISTRAR Robert E. Fisher, R.D.	
25C. FUNERAL DIRECTOR Frank D. Chickens		25D. ADDRESS 1129 N. Camden St			

ACADEMY OF NATURAL SCIENCES

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ACADEMY OF NATURAL SCIENCES

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BALTIMORE CITY HEALTH DEPARTMENT

71 4032

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 4032

BIRTH NO.		1. NAME OF DECEASED <u>Wilhelmina A. Miller</u>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> <u>April 24, 1971</u> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		3. DATE PRONOUNCED DEAD Month Day Year Hour <u>4 24 71 1:15 p</u> M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>906</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>1849 00 1847 E. 29th St.</u>		6. SEX <u>female</u> 7. RACE <u>white</u> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <u>4-6-28 2887</u>		10. AGE (In years last birthday) <u>42</u>		E. STREET AND NUMBER <u>1849 1847 E. 29th St.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William A Miller</u>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Maker</u>		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <u>Anna S Kaufmann</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		17. SOCIAL SECURITY NO. <u>220-44-7783</u>		18. INFORMANT <u>Mrs Grace Randall</u> ADDRESS <u>Glendale, Cal 1339 B East Harvard St.</u>	
19. <u>412.4</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
20A. DATE OF OPERATION <u>0</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <u>No</u>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23.		I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Werner U. Spitz</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Werner U. Spitz, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
		Deputy Chief Medical Examiner		4/25/71	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-27-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cem.</u>	
				24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 26 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Balto. Md. Leonard J Ruck Inc. 21214</u>	

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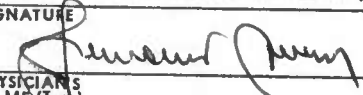
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 4033
BIRTH NO. 71 4033		1. NAME OF DECEASED (Type or Print) CATHERINE F. WEGER		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 003319 Grenton Ave.		2. DATE AND HOUR OF DEATH April 24, 1971 5 A.M.		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2741		
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 3319 Grenton Avenue		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/21/1874	9. AGE (In years last birthday) 96
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME August Ricker		14. MOTHER'S MAIDEN NAME Mary Rupert		
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-01-4158		17. INFORMANT Mr. Joseph R. Weger
				ADDRESS Same
18. 284 X I CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Aploptic anemia DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Sensitivity DUE TO, OR AS A CONSEQUENCE OF:		
		(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from Sept. 3 1969 to 4/22/71 19____ that (I) (we) last saw the deceased alive on 4/22/71 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE 		23B. DATE SIGNED 4/24/71		23C. PHYSICIAN'S NAME (Type) Dr. Fernando Juliao
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/27/71		24C. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer Cem.
25A. DATE REC'D BY HEALTH DEPT. APR 26 1971		25B. NAME OF REGISTRAR Robert E. Fahey, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc., Balto. 14, Md.
				ADDRESS Baltimore Maryland



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 4034</u>	
BIRTH NO. <u>71 4034</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Bianca, Luigi S.</u>			2. DATE AND HOUR OF DEATH <u>4/23/71</u> <u>9:10 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2734</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>44 Union Memorial Hosp</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <u>4030 E. Chodale Avenue</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-01-00</u>	9. AGE (in years last birthday) <u>70</u>	If Under 1 Yr. Months: Oys: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Produce Clerk</u>			11. BIRTHPLACE (State or foreign country) <u>ITALY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>?</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>216-01-6863</u>		17. INFORMANT <u>Mrs. Rose Lambertina</u>
18. <u>43601</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cerebro vascular accident</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE OLD INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW OLD INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/17</u> 19 <u>71</u> to <u>4/23</u> 19 <u>71</u> that (I) (we) lost saw the deceased alive on <u>4/23</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>I Chail</u>			23B. DATE SIGNED <u>4/23/71</u>		23C. PHYSICIAN'S NAME (Type) <u>ISSAM CHEIKH</u>
23D. ADDRESS <u>Union Memorial Hospital</u>			23E. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/27/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Most Holy Redeemer Cem.</u>	
24D. LOCATION <u>Baltimore Maryland</u>		24E. NAME OF FUNERAL DIRECTOR <u>Leonard J. Ruck Inc.</u>		24F. ADDRESS <u>5305 Harford Rd.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 26 1971</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

71 4035		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 71 4035	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) John A. ZABLOCKI			
2. DATE AND HOUR OF DEATH 4/24/71 at 12¹⁵ a.m.				M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		A. STATE Maryland		B. COUNTY Balto.	
C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER 5126 Henry Avenue			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-20-99		9. AGE (in years last birthday) 71	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Clerk		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USAmerican	
13. FATHER'S NAME Unknown Alexander Zablocki				14. MOTHER'S MAIDEN NAME Unknown Mary			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 214 20 1809		17. INFORMANT ADDRESS John B. Zablocki same			
18. 44-391 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Pulmonary embolus				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). generalized arteriosclerosis							
19A. DATE OF OPERATION 4/21/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED peripheral vascular disease		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/11/1971 to 4/24/1971 that (I) (we) last saw the deceased alive on 4/24/1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Stallion Hanna M.D.				23B. DATE SIGNED 4/24/1971		23C. PHYSICIAN'S NAME (Type) Stallion Hanna	
23D. ADDRESS							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/27/71		24C. NAME of CEMETERY or CREMATORY St. Stanislaus		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 26 1971		25B. NAME OF REGISTRAR Robert E. Jaber, R.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc.		ADDRESS Balto. Md.	

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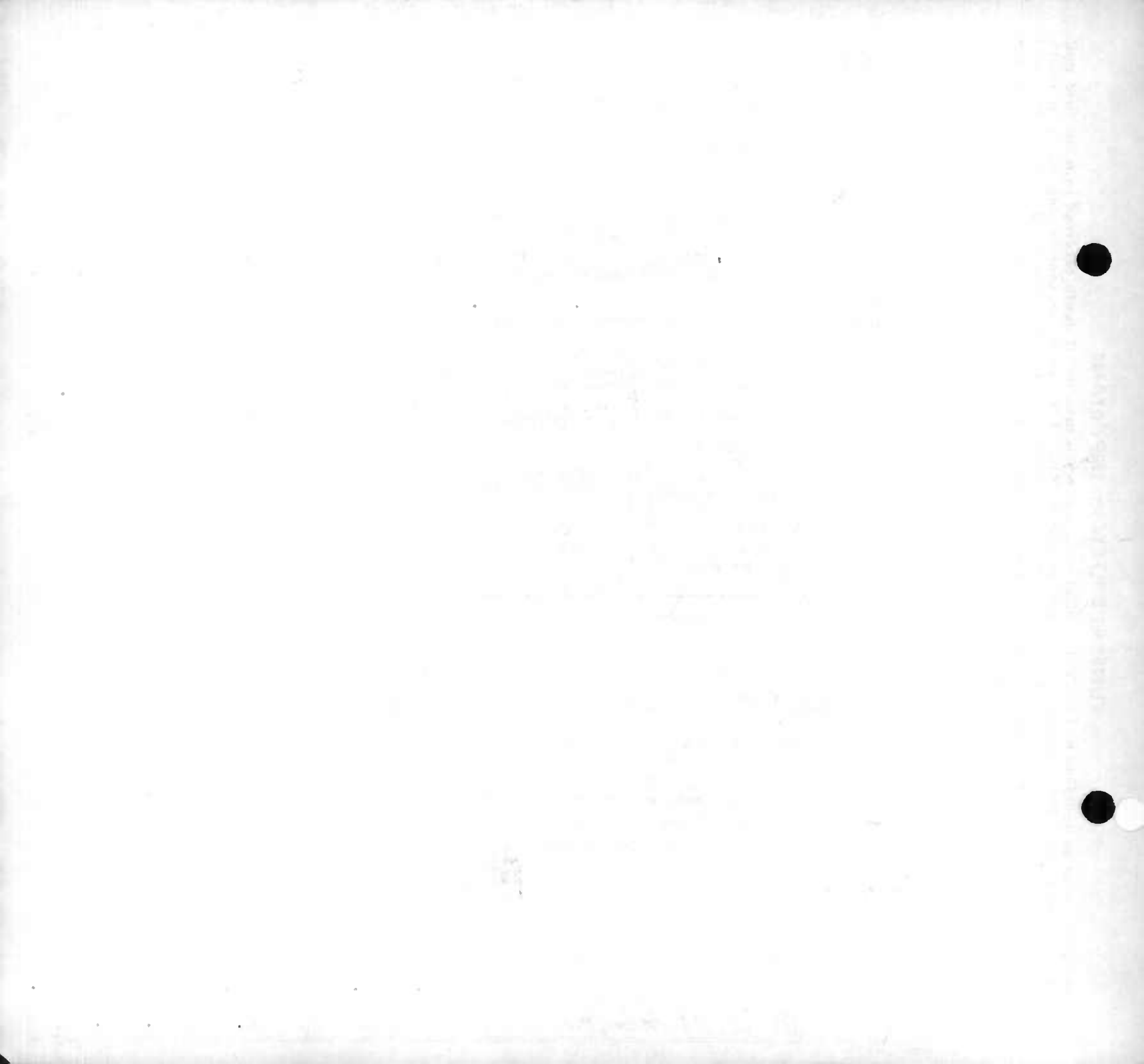
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

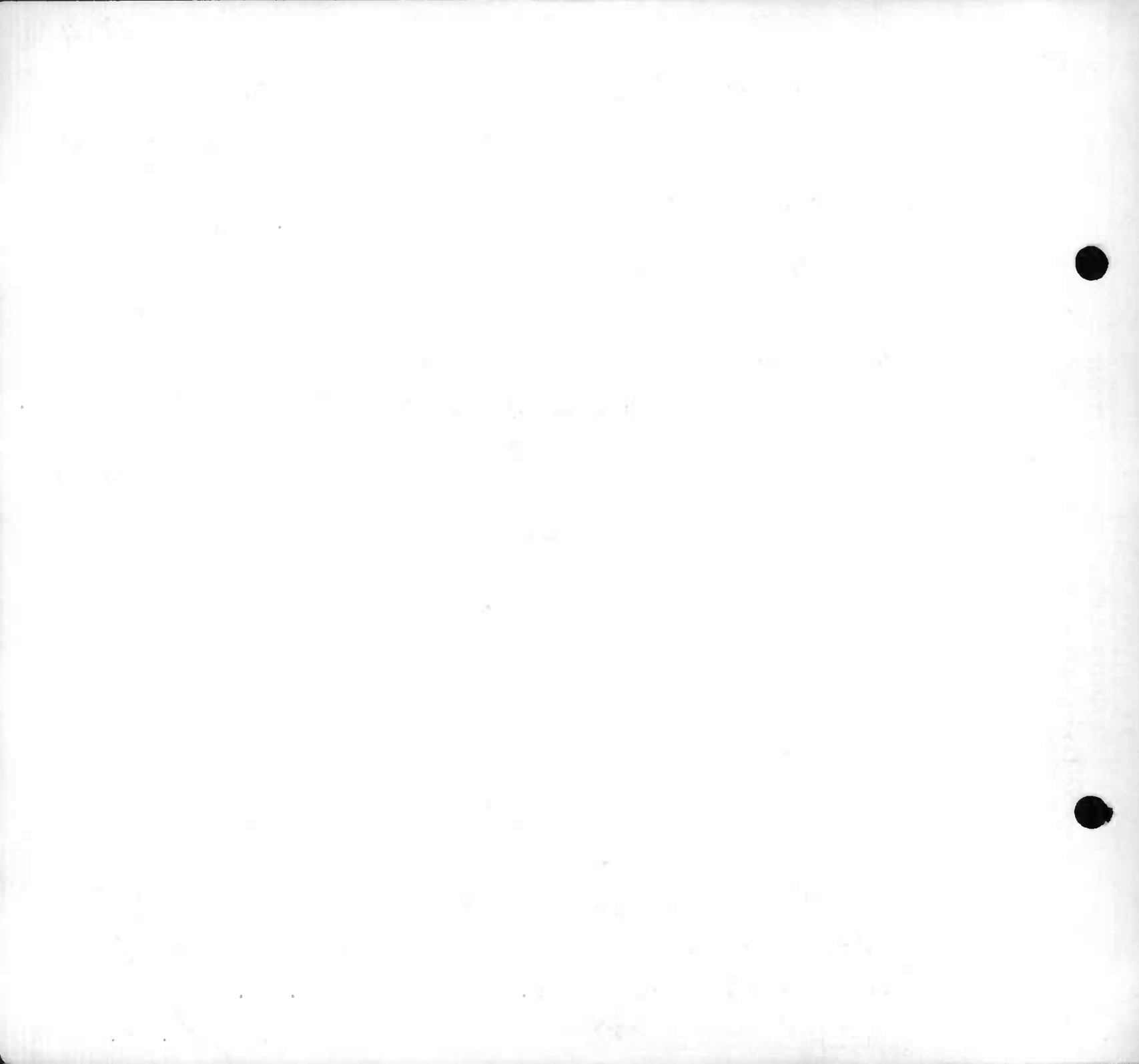
VS 150-REV. 1/1/68



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

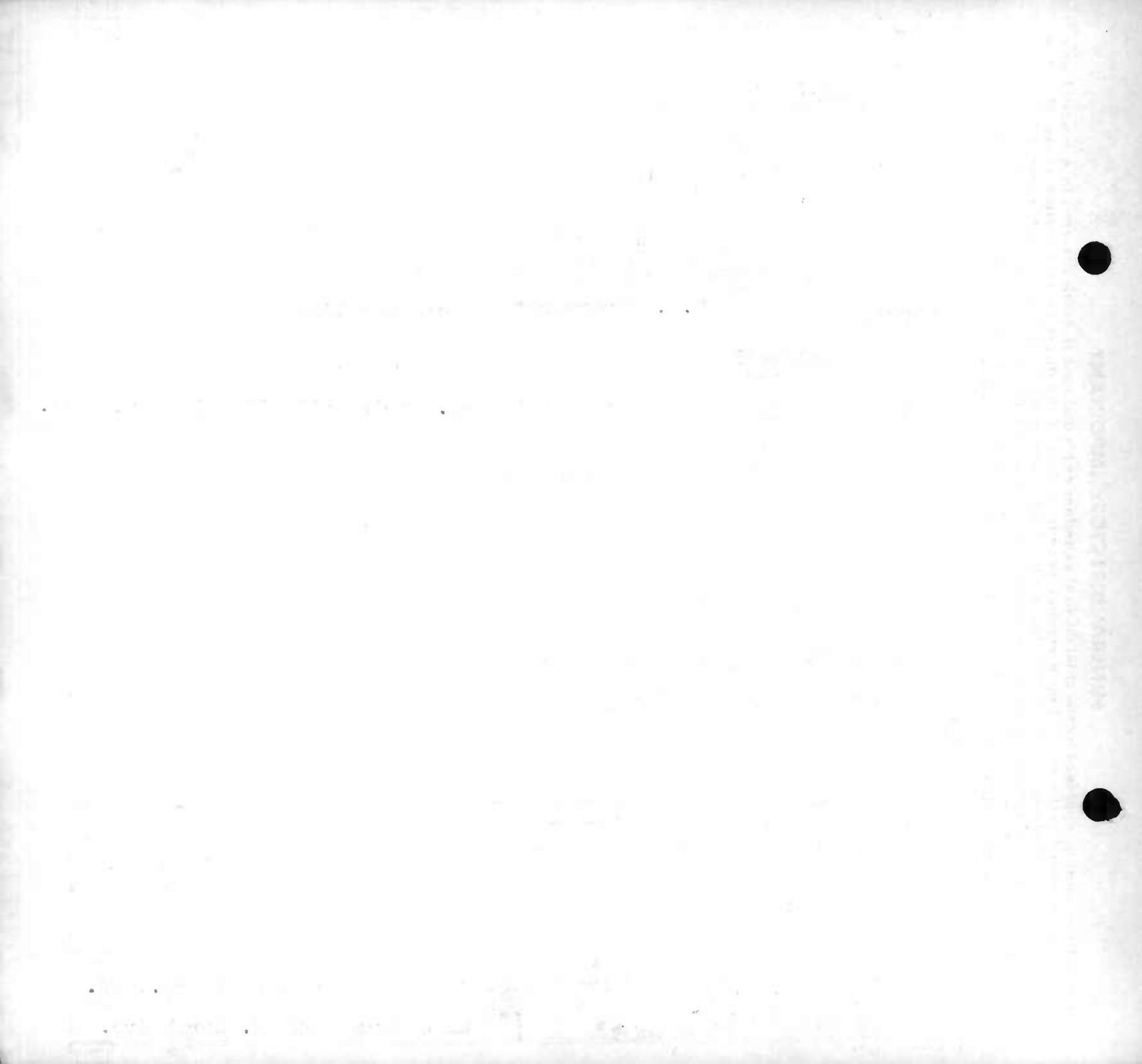
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		71-4037		71-4037		71-4037	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		REG. NO.		71-4037		71-4037	
ANITA SOOT		4/25/71 11:04 A.M.		71-4037		71-4037		71-4037	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY					
*6 Lutheran Hosp. of Md.				Md., 6311 Pioneer Dr., Baltimore					
C. CITY OR TOWN				D. INSIDE CITY LIMITS?					
Baltimore				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
E. STREET AND NUMBER				6311 Pioneer Dr. 21214 2706					
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Female		W.		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11/6/08		62	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)	
Lab. Tech.								ESTONIA	
12. CITIZEN OF WHAT COUNTRY?				USA					
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
Georg H Foidemann				Louise Auner					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No				214-30-3735		Mrs Anne L Deliau		9245 West Stayman Dr.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				3 mos	
ANTECEDENT CAUSES				(B) CARCINOMATOSIS					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) CARCINOSARCOMA of uterus					
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
4/20/71		Ca		No					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from				19 71 to present					
that (I) (we) last saw the deceased alive on				19 71 and that in (my) (our) opinion death occurred on the date					
and hour and from the causes stated above. (I) (We) did (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED				4/25/71	
Sylvan Frieman MD				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
Sylvan Frieman				5- Veleet Ridge Rd. Owings Mills Md.					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		5-1-71		Parkwood Cem.		Balto. Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
APR 26 1971		Jabert E. Jabert MD		Leonard J Ruck Inc		Balto. Md. 21214			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

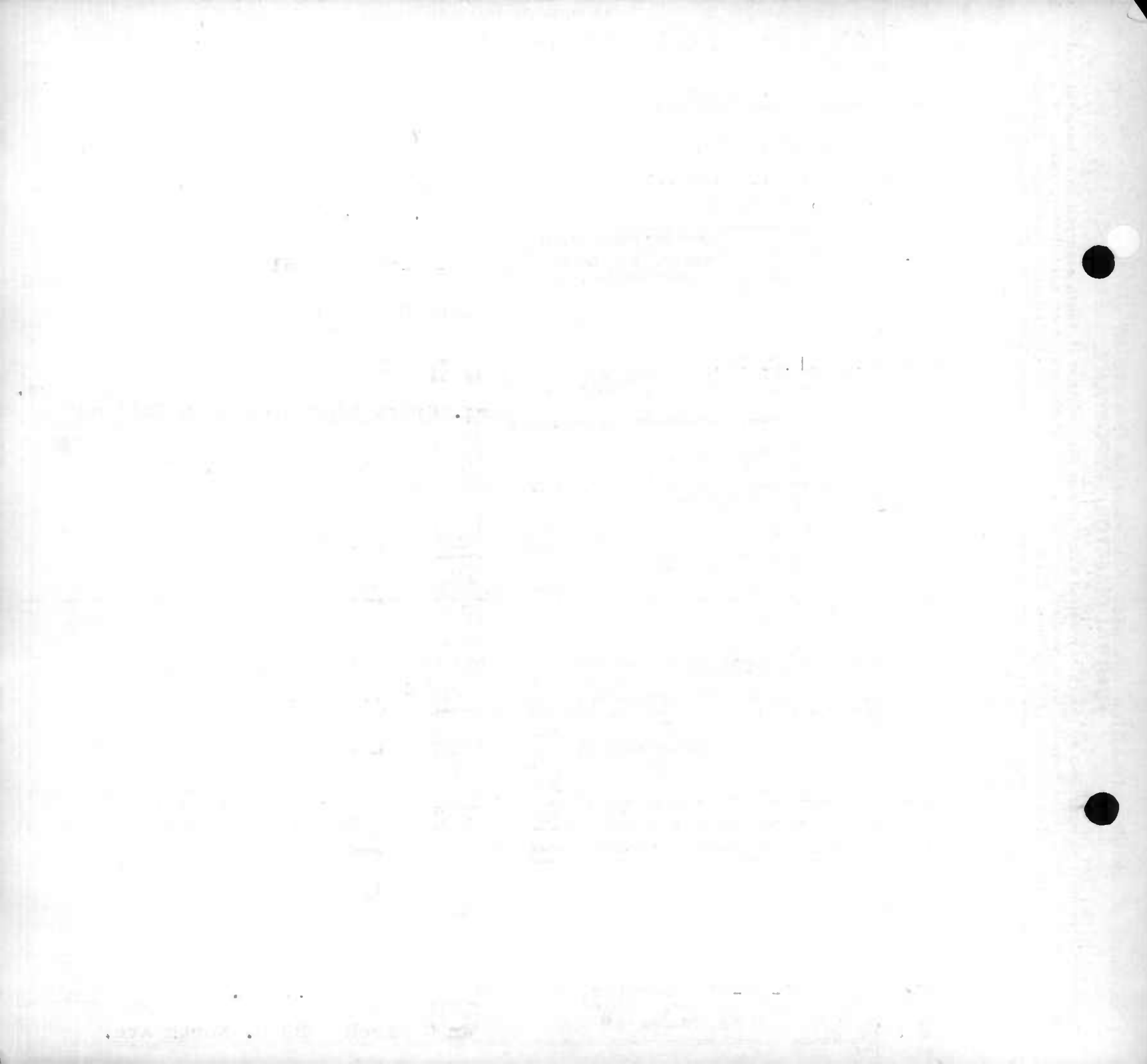
BALTIMORE CITY HEALTH DEPARTMENT										
71 4038 CERTIFICATE OF DEATH					REG. NO. 71 4038					
1. NAME OF DECEASED (Type or Print) EMMIT CALDWELL					2. DATE AND HOUR OF DEATH 4/24/71 at 5:30 pm					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21225					C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX MALE 6. RACE NEGRO 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 01-26-96		9. AGE (in years last birthday) 75		10. CITIZEN OF WHAT COUNTRY South Carolina	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer					10B. KIND OF BUSINESS OR INDUSTRY U.S. Government					
13. FATHER'S NAME GEORGE Caldwell					14. MOTHER'S MAIDEN NAME SALLIE SMITH					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI					16. SOCIAL SECURITY NO. 215-03-9172					
17. INFORMANT Mrs. Carrie Caldwell					ADDRESS 7419 Beach Ave.					
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (this hospital) attended the deceased from 03-23 1971 to 04-24-71 19 that (we) last saw the deceased alive on 04-24-71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death. 23A. SIGNATURE Paul W. Helton M.D. BCh. BAO 23B. DATE SIGNED 4/24/71 23C. PHYSICIAN'S NAME (Type) PAUL WHELTON M.D. BCh. BAO 23D. ADDRESS JOHNS HOPKINS HOSP. 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 4/29/71 24C. NAME of CEMETERY or CREMATORY Mt Calvary Cemetery 24D. LOCATION Anne Arundel Cty., Md. 25A. DATE REC'D BY HEALTH DEPT. APR 26 1971 25B. NAME OF REGISTRAR J. C. E. Faby 25C. FUNERAL DIRECTOR Wm C March 25D. ADDRESS 928 E. North Ave.										



THE BODY OF ARTHUR SINGLETON HAS BEEN RELEASED AS NON MED BY
FUNERAL DIRECTOR: IMPORTANT

DR LINTHICUM OF THE MEDICAL EXAMINER'S OFFICE
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4039	
BIRTH NO. S-524 71 4039				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) ARTHUR SINGLETON			2. DATE AND HOUR OF DEATH 4/24/71 at 5:45pm. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY MARYLAND 802		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX MALE			6. RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 04-10-10			9. AGE (In years last birthday) 61		10. UNDER 1 Yr. Months Days 11. UNDER 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME West WESS SINGLETON		
14. MOTHER'S MAIDEN NAME EMMA LYONS			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT Mrs. Grace Singleton 1705 Collington Ave.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH 491X I Cardio-Respiratory Arrest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) Emphysema / Ar. Bronchitis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (if) (this hospital) attended the deceased from 04-23 1971 to 04-24 1971 that (if) (we) last saw the deceased alive on 04-24 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (if) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Paul Whelton M.D. Bch. BAS. DEGREE			23B. DATE SIGNED 4/24/71		23C. PHYSICIAN'S NAME (Type) PAUL WHELTON M.D. Bch. BAS. DEGREE
23D. ADDRESS JOHNS HOPKINS HOSP.			24A. BURIAL CREMATION REMOVAL (Specify) Burial		
24B. DATE 4-28-71			24C. NAME of CEMETERY or CREMATORY Arbutus Mem Park		24D. LOCATION Balto., Md.
25A. DATE REC'D BY HEALTH DEPT. APR 26 1971			25B. NAME OF REGISTRAR Wm C March		25C. FUNERAL DIRECTOR 928 E. North Ave.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

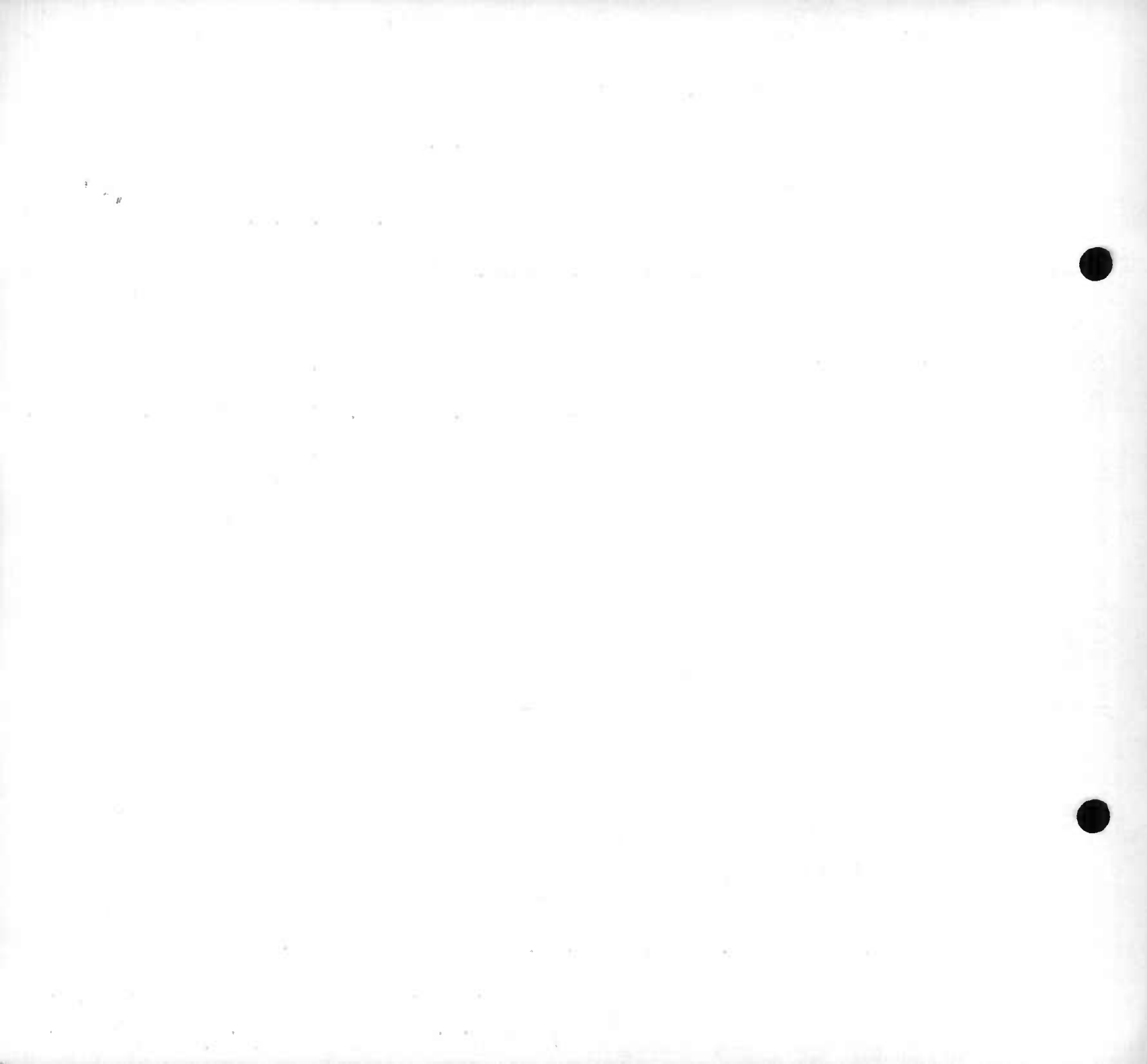
F-623 71 4040		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 4040	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Katherine B. Forsythe		4-22-71 1:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 90 Long Green Nursing Home		A. STATE Md.		B. COUNTY 2759	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 4419 Marble Hall Rd.			
5. SEX F.	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-5-1890	9. AGE (In years last birthday) 80	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		10B. KIND OF BUSINESS OR INDUSTRY Humble Oil		11. BIRTHPLACE (State or foreign country) Richmond, Virginia	
13. FATHER'S NAME F. E. Lang		14. MOTHER'S MAIDEN NAME Josephine Allen		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-09-3981A		17. INFORMANT Margaret Fogarty	
				ADDRESS Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 4409 I		CAUSE OF DEATH (A) IMMEDIATE CAUSE Inferiority of Age DUE TO, OR AS A CONSEQUENCE OF: Marked Arteriosclerosis (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>March 23</u> 1971 to <u>April 22</u> 1971 that (I) (we) last saw the deceased alive on <u>April 22</u> 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Thos G Abbott</u>		23B. PHYSICIAN'S NAME (Type) Dr. Thomas G. Abbott M. D.		23C. DATE SIGNED 4-23-71	
23D. ADDRESS 4509 Liberty Hgts. Ave.		23E. DEGREE		23F. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-24-71		24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	
24D. LOCATION Baltimore County, Maryland		24E. DATE REC'D BY HEALTH DEPT. APR 26 1971		24F. NAME OF REGISTRAR Robert E. Jenkins, Jr.	
24G. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		24H. ADDRESS 4905 York Rd. Baltimore, Md. 21212		24I. DATE APR 26 1971	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

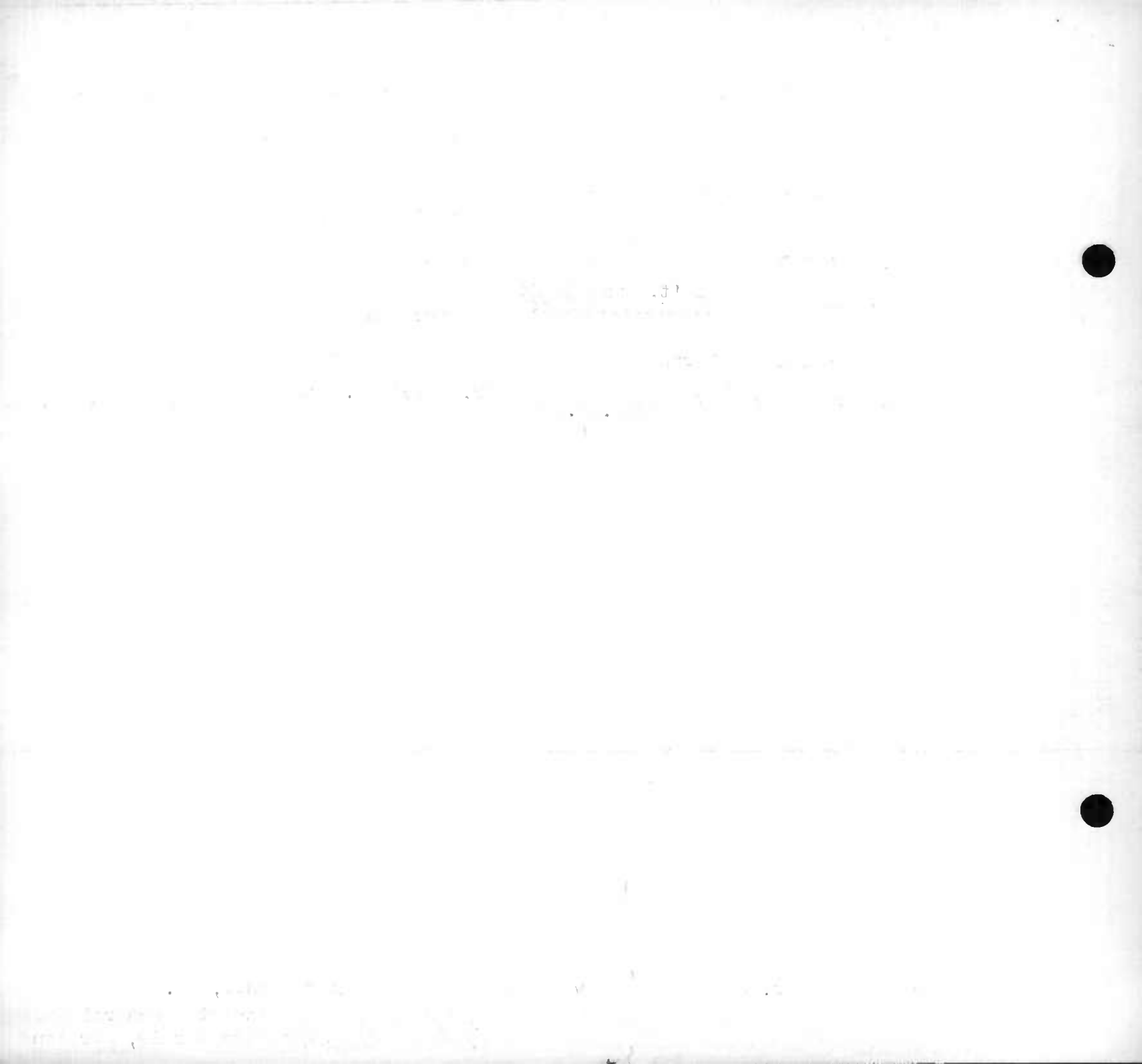
W-250 71 4041		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 4041	
1. NAME OF DECEASED (Type or Print) Beatrice A. Whigham		2. DATE AND HOUR OF DEATH 4-25-71 5:05 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Long Green Nursing Home		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE D.C. B. COUNTY V-48 C. CITY OR TOWN Washington D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 926 Mass. Ave. N.W.			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-26-1889	9. AGE (In years last birthday) 82	10. If Under 1 Yr. Months Days; If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Michael J. Hand		14. MOTHER'S MAIDEN NAME Harriet A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 579-64-8484		17. INFORMANT ADDRESS Mr. James J. Hand 3100 St. Paul St.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 4-4-71 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 14 Feb 71 to Apr 25 71 that (I) (we) last saw the deceased alive on Apr 22 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE [Signature] MD DEGREE 23B. DATE SIGNED 4-26-71 23C. PHYSICIAN'S NAME (Type) Dr. William C. Helfrich M. D. 23D. ADDRESS 5006 Roland Ave. 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 4-28-71 24C. NAME OF CEMETERY OR CREMATORY Arlington Nat'l. Cem. 24D. LOCATION (City, town, or county) (State) Arlington Virginia 25A. DATE REC'D BY HEALTH DEPT. APR 28 1971 25B. NAME OF REGISTRAR [Signature] 25C. FUNERAL DIRECTOR H.W. Jenkins, Sons Co. 4905 York Rd. Baltimore, Md. 21212					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		71 4042		REG. NO. 71 4042	
BIRTH NO. 7-524		71 4042		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Mary Fenzel</i>			2. DATE AND HOUR OF DEATH <i>4/24/71</i> <i>3:40 AM</i> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Lutheran Hospital of Maryland</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. CITY <i>Anne Arundel</i> <i>5200</i>		
5. SEX <i>Female</i>			6. RACE <i>white</i>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <i>9-3-16</i>		
9. AGE (in years last birthday) <i>54 yrs.</i>			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sales Clerk</i>		
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>			12. CITIZEN OF WHAT COUNTRY <i>USA</i>		
13. FATHER'S NAME <i>Mendoza Marsh</i>			14. MOTHER'S MAIDEN NAME <i>(unknown)</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO. <i>217.07.6768</i>		
17. INFORMANT <i>Mr. Melvin L. Fenzel (son)</i>			ADDRESS <i>Glen Burnie, Md</i>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>I</i> <i>Carcinoma of ovary (Metastatic)</i> <i>Carcinoma of ovary.</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>19</i> to <i>19</i> that (I) (we) last saw the deceased alive on <i>19</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>P. Byron M.D.</i>			23B. DATE SIGNED <i>4-24-71</i>		
23C. PHYSICIAN'S NAME (Type) <i>PRAYOON BUNPIAN</i>			23D. ADDRESS <i>Lutheran Hospital, Baltimore, Md.</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Apr. 27/71</i>		24C. NAME of CEMETERY or CREMATORY <i>Glen Haven Memorial Park</i>	
24D. LOCATION (City, town, or county) (State) <i>Glen Burnie, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>APR 26 1971</i>		25B. NAME OF REGISTRAR <i>Richard L. Singleton</i>	
25C. FINAL DISPOSITION <i>Singleton Federal Home</i>		25D. ADDRESS <i>Glen Burnie, Maryland</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

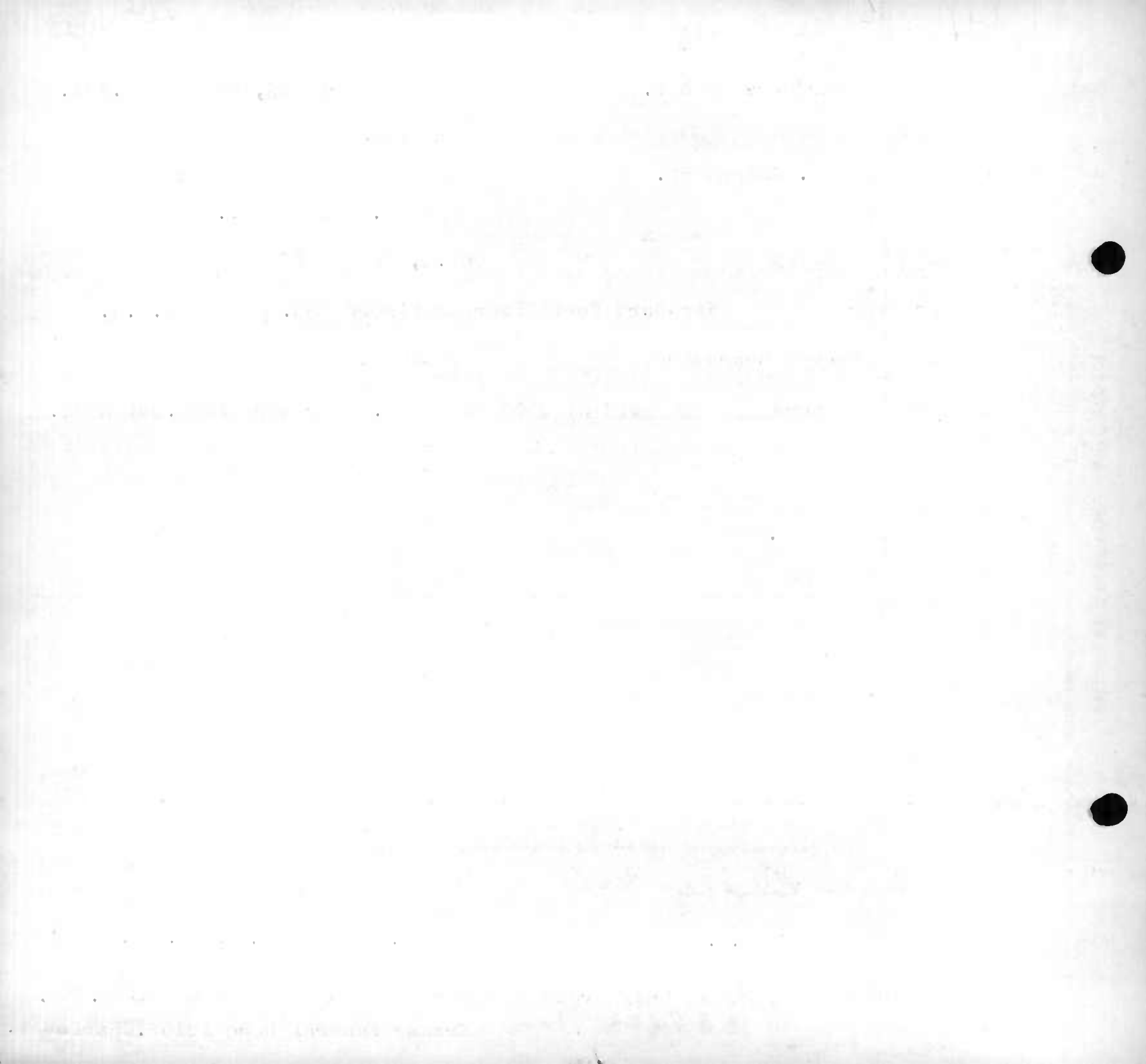
BIRTH NO. U-460 71 4043		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH X		REG. NO. 71 4043	
1. NAME OF DECEASED (Type or Print) <u>Wheeler, Clinton C.</u>			2. DATE AND HOUR OF DEATH <u>7th April 23rd 1971</u> A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>8 University Hospital</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Anne Arundel</u> <u>5200</u> C. CITY OR TOWN <u>Severn</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>Newcut Box 260 Newcut Rd</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/28/19</u>	9. AGE (in years last birthday) <u>51</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	11. BIRTHPLACE (State or foreign country) <u>Severn, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>William W. Wheeler</u>			14. MOTHER'S MAIDEN NAME <u>Mary Estella Watts</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> <u>////////////////////</u>		16. SOCIAL SECURITY NO. <u>217.05.3996</u>	17. INFORMANT <u>Mrs. Alice Wheeler (wife) Same as #18 #4</u>		
18. <u>207.91</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Stem Cell Leukemia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>4/13</u> 19 <u>71</u> to <u>4/23</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>4/23</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Lawrence Hill</u>			23B. DATE SIGNED <u>4/23/71</u>		23C. PHYSICIAN'S NAME (Type) <u>DEGREE</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>April 26/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Glen Haven Memorial Park</u>
24D. LOCATION <u>Glen Burnie, Maryland</u>			25A. DATE REC'D BY HEALTH DEPT. <u>APR 26 1971</u>		
25B. NAME OF REGISTRAR <u>Robert P. Fisher, Jr.</u>			25C. FUNERAL DIRECTOR <u>R. Singleton</u>		
25D. ADDRESS <u>Singleton Funeral Home</u>			<u>Glen Burnie, Maryland</u>		

X

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4044	
BIRTH NO. B-635		71 4044		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Beardmore John F.			2. DATE AND HOUR OF DEATH April 23, 1971 8:30A.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 118 W. Ostend St.			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 118 W. Ostend St.		
5. SEX male	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 4, 1895	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Standard Fertilizer		11. BIRTHPLACE (State or foreign country) Baltimore Md.	
13. FATHER'S NAME George Beardmore			14. MOTHER'S MAIDEN NAME Susie ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no none		16. SOCIAL SECURITY NO. 215 01 2606		17. INFORMANT Jennie D. Beardmore	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CARCINOMA of neck (right side) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. SECONDARY ANEMIA		CAUSE OF DEATH CARCINOMA of neck (right side) (A) IMMEDIATE CAUSE with general metastases DUE TO, OR AS A CONSEQUENCE OF: SECONDARY ANEMIA (B) DUE TO, OR AS A CONSEQUENCE OF: (C).....		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH about 1 year ?	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (HE WAS HE) attended the deceased from June 26, 1970 19 to April 23, 1971 19, that (I) (WE) last saw the deceased alive on April 22, 1971 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (WE) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Harry Deibel M.D.</i>				23B. DATE SIGNED 4/24/71	
23C. PHYSICIAN'S NAME (Type) HARRY DEIBEL M.D.				23D. ADDRESS 1226 S. HANOVER ST. BALTO. MD. 21230	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/26/71		24C. NAME of CEMETERY or CREMATORY Holy Cross Cemetery	
24D. LOCATION (City, town, or county) (State) Ritchie Highway Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. APR 25 1971			
25B. NAME OF REGISTRAR <i>Robert E. Krause</i>		25C. FUNERAL DIRECTOR Krause Funeral Home 1216 S. Charles St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>M-245</u>		71 4045		X		REG. NO. <u>71 4045</u>	
1. NAME OF DECEASED (Type or Print) <u>Joseph E. McCollum, Sr.</u>				2. DATE AND HOUR OF DEATH <u>4/22/71 4 45 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>3/ Balto City Hospitals</u> <u>Baltimore, Md. 21224</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>7944 Gough St.</u> <u>21224 005</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/11/90</u>	9. AGE (In years, months, days) <u>81</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel Co.</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>William McCollum</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-09-4292</u>		17. INFORMANT <u>4940 Eastern Avenue</u> ADDRESS <u>BCH-Records Baltimore, Md. 21224</u>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Stroke</u> <u>2 weeks</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>4/8/71</u> 19 <u>71</u> to <u>4/22/71</u> 19 <u>71</u> that (I) (we) lost saw the deceased alive on <u>4/22/71</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Allen Krumholtz</u>				23B. DATE SIGNED <u>4/22/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Allen Krumholtz</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/24/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Oak Lawn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 26 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>John J. Duda,</u>		25D. ADDRESS <u>7922 Wise Ave. Dundalk, Md.</u>	

Order City Hospital

1944 4444

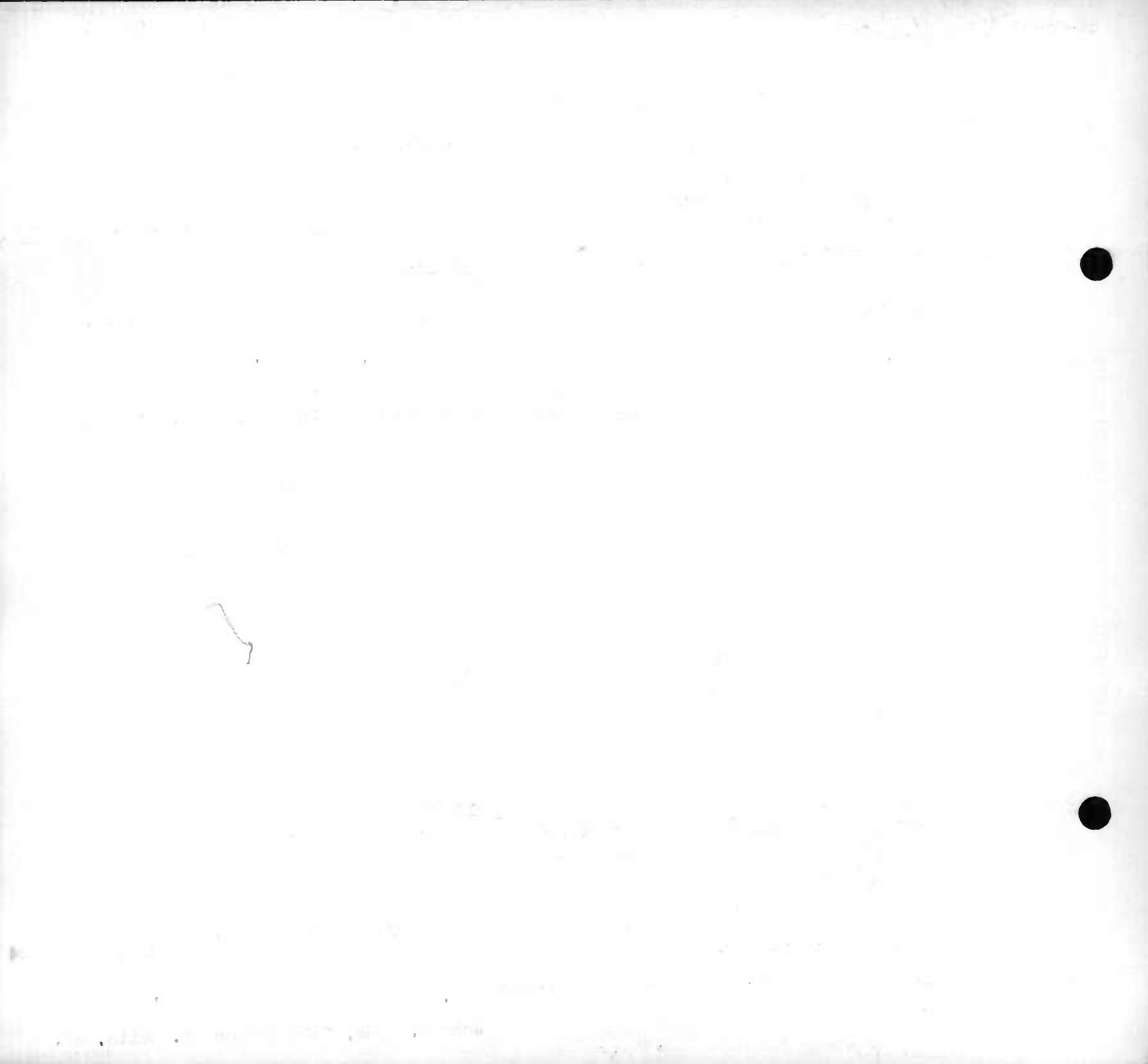
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1940 Eastern

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		71 4046		BALTIMORE CITY HEALTH DEPARTMENT		71 4046	
1. NAME OF DECEASED (Type or Print) <u>Gehrmann, Madeleine E.</u>				2. DATE AND HOUR OF DEATH <u>4/21/71</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>				A. STATE <u>Maryland</u>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>Belt</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Female</u>				6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>1-26-92</u>		9. AGE (in years last birthday) <u>79</u>	
13. FATHER'S NAME <u>Boyer, Raymond</u>				14. MOTHER'S MAIDEN NAME <u>Gabsky, Julia M.</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-46-0631</u>		17. INFORMANT <u>4940 Eastern Avenue</u> <u>BCH: Records Baltimore, Maryland 21224</u>			
18. <u>402X1</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Stroke</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Hypertension</u> <u>heart disease</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>4/18/71</u> 19 <u>71</u> to <u>4/21/71</u> 19 <u>71</u> that (we) last saw the deceased alive on <u>4/21/71</u> 19 <u>71</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Allan Krumholz, M.D.</u>				23B. DATE SIGNED <u>4/21/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Allan Krumholz, M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/26/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 26 1971</u>		25B. NAME OF REGISTRAR <u>John J. Duda</u>		25C. FUNERAL DIRECTOR <u>John J. Duda, 2829 Hudson St. Balto. Md.</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-200		71 4047		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO.		71 4047	
BIRTH NO.		1. NAME OF DECEASED Type or Print TILLIE ELLA COOK				2. DATE AND HOUR OF DEATH 4-21-71 6:00 P.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD North Charles General Hospital						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN Dundalk D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2904 Plainfield Road					
5. SEX F	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 16, 1897		9. AGE (in years last birthday) 73		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME JAMES ZIKA				14. MOTHER'S MAIDEN NAME BARBARA FURST				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 218-01-4477-B				17. INFORMANT Son: 2904 Plainfield Road Ralph G. Cook, Dundalk, Md. 21222							
18. 450X1 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary Embolism (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)					
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 3-10 19 71 to 4-21 19 71 that (I) (we) last saw the deceased alive on 4-21 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Emmanuel M. Mariago M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4-21-71					
23C. PHYSICIAN'S NAME (Type) EMMANUEL M. MARIAGO M.D.				23D. ADDRESS NORTH Charles Gen. Hospital							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-26-71		24C. NAME of CEMETERY or CREMATORY Holy Redeemer		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. APR 26 1971		25B. NAME OF REGISTRAR Robert J. ...		25C. FUNERAL DIRECTOR ADDRESS John J. Duda 7922 Wise Ave. Dundalk, Md.							

11-60

RECEIVED CIVIL SERVICE COMMISSION

F WHITE

MARYLAND

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

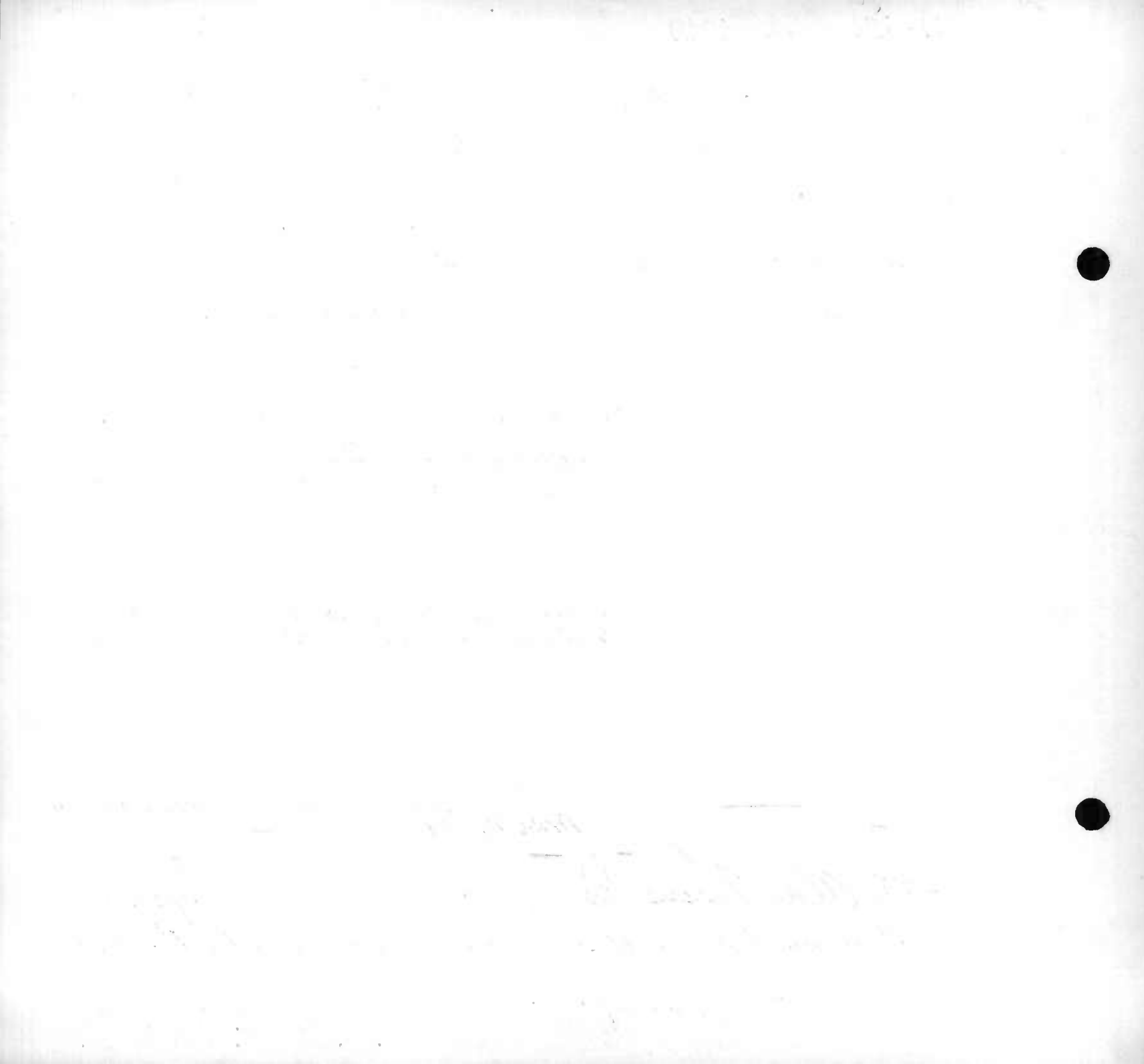
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					REG. NO. 71 4048				
BIRTH NO. R-320		1. NAME OF DECEASED (Type or Print) <u>J. Carroll Rhodes, Sr.</u> <u>JOSEPH C. RHODES, Sr.</u>			2. DATE AND HOUR OF DEATH <u>4/22/71</u> <u>6:30 P.M.</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>BON SECOURS HOSPITAL</u> <u>2000 W. FAYETTE ST.</u> <u>BALTIMORE, MD 21223</u>					A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>				
					C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
					E. STREET AND NUMBER <u>611 NORTH BEND RD.</u>				
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/15/96</u>	9. AGE (In years last birthday) <u>75y.</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance (Salesman)</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (State or foreign country) <u>Wye Mills MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Henry Rhodes</u>					14. MOTHER'S MAIDEN NAME <u>Susan Catherine Callahan</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes Army 1914 W W I</u>				16. SOCIAL SECURITY NO. <u>215-01-1675</u>		17. INFORMANT <u>Wife - Mrs. Josephine E. Rhodes</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Septicemia</u>					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>As purulent pneumonia</u>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Dissecting aortic aneurysm</u>					(B) DUE TO, OR AS A CONSEQUENCE OF: <u>1 mo</u>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION <u>2-23</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Dissecting aortic aneurysm</u>			20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>March 20</u> 19 <u>71</u> to <u>April 22</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>April 22</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>S. G. Sullivan</u>					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <u>4-23-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>S. G. Sullivan</u>					23D. ADDRESS <u>1129 St Paul St Baltimore Md</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/26/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 26 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Md</u>		25C. FUNERAL DIRECTOR <u>Starling Funeral & Estate</u> <u>736 Edmondson Ave.</u> <u>Catonsville, Md. 21228</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-536 71 4048				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 4048	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Goldie A. Minter				2. DATE AND HOUR OF DEATH 4/22/71 5:30 AM J39			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 00 719 N. Carey Street				A. STATE Maryland		B. COUNTY 16 01	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 719 N. Carey St.			
5. SEX Female	6. RACE Negroe	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-28-94	9. AGE (In years last birthday) 77	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Northumberland Co., Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Billy Carter				14. MOTHER'S MAIDEN NAME Tina Gray			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -----		16. SOCIAL SECURITY NO. 217-01-4734		17. INFORMANT Ruth Jackson 2207 Mura St.			
18. 41221 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 1) HYPERTENSION, ESSENTIAL 3) RHEUMATOID ARTHRITIS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH UNK UNK UNK			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JUN 1970 to APRIL 22, 1971 that (I) (we) last saw the deceased alive on APRIL 18, 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE N. Alan Harris, M.D.				23B. DATE SIGNED 4/23/71		23C. PHYSICIAN'S NAME (Type) N. ALAN HARRIS, M.D.	
23D. ADDRESS 4200 EDMONDSON AVE, BALTO., MD.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial					
24B. DATE 4-26-71		24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Arbutus, Maryland			
25A. DATE REC'D BY HEALTH DEPT. APR 26 1971		25B. NAME OF REGISTRAR Robert E. Bailey, M.D.		25C. FUNERAL DIRECTOR Vernon R. Bailey			
				ADDRESS Kelson F. H. 1348 N. Calhoun St.			



FUNERAL DIRECTOR: IMPORTANT

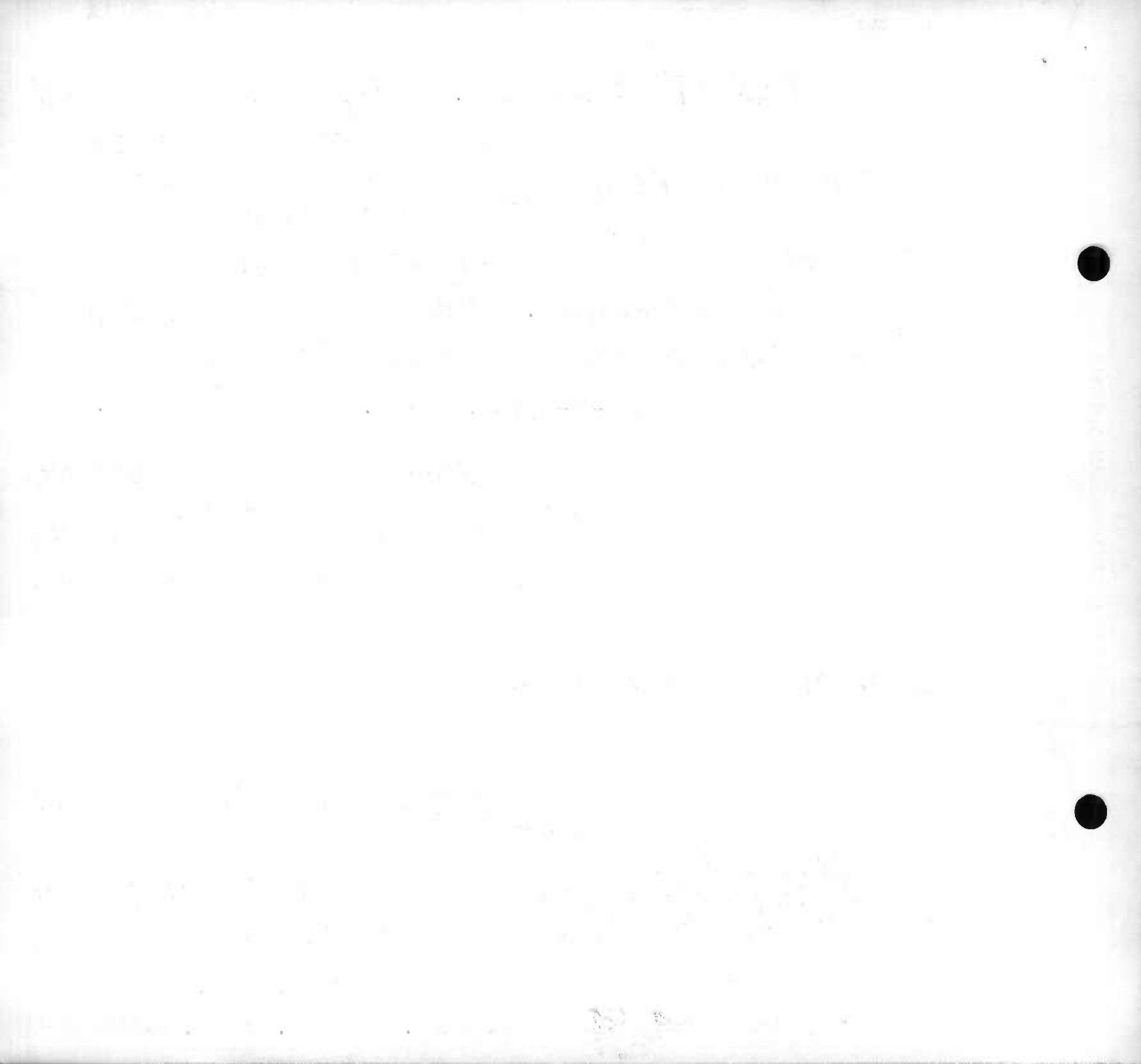
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 4050</u>	
<u>14-625</u> BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>Hilda F. Harrigan</u>		71 4050 CERTIFICATE OF DEATH 2. DATE AND HOUR OF DEATH <u>4/21/71</u> <u>6:30 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 Mount Sinai Nursing Home</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1201</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3511 Newland Road</u>			
5. SEX <u>F.</u>	6. RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/1/96</u>	9. AGE (In years last birthday) <u>75</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John Frederick</u>		14. MOTHER'S MAIDEN NAME <u>Emma Gocking</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Hilda Fallon</u> ADDRESS <u>3511 Newland Rd.</u>	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>CVA Rt Hemiplegia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Coronary Insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Hypertension</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/17/71</u> 19 <u>to</u> <u>4/21</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>4/20</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>E. S. Kallins MD</u>				23B. DATE SIGNED <u>4/21/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>E. S. KALLINS MD</u>				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/24/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 26 1971</u>			
25B. NAME OF REGISTRAR <u>John A. Moran, Inc.</u>		25C. FUNERAL DIRECTOR <u>John A. Moran, Inc.</u> ADDRESS <u>3000 E. Baltimore St</u>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

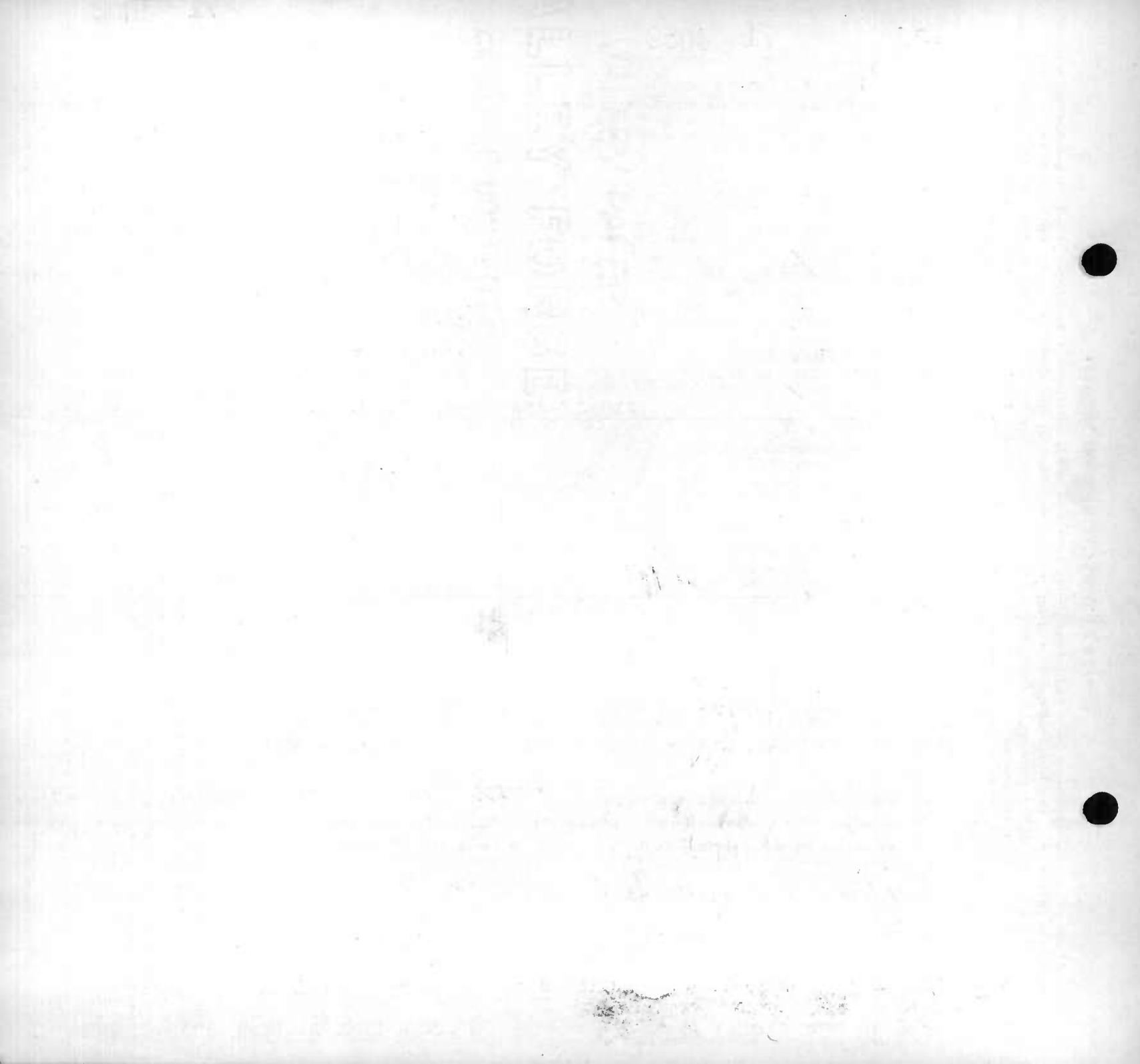
A-130		71 4051		BALTIMORE CITY HEALTH DEPARTMENT		71 4051	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
ABBO T E LOISE M.				4/20/71 11:15 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION SOUTH BALTIMORE GENERAL 43				A. STATE Md. B. COUNTY BALTIMORE 5300			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN BALTIMORE			
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER 7055 Dunbar Rd.			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-29-10	9. AGE (in years, last birthday) 60	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Press Operator		10B. KIND OF BUSINESS OR INDUSTRY National Can. Co.		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Kleckner				14. MOTHER'S MAIDEN NAME Kate Montag			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 276-09-7439		17. INFORMANT Mr. Edwin B. Abbott		ADDRESS 7055 Dunbar Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANAEMIA GASTRO-INTESTINAL BLEEDING SECONDARIES IN LIVER. (B) DUE TO, OR AS A CONSEQUENCE OF: GENERALISED ABDOMINAL CARCINOMATOSIS.			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months. 3 months. 3 months.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 3-26-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED G.I. bleeding		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3-22-71 to 4-20-71 that (I) (we) last saw the deceased alive on 4-20-71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Harjit Singh M.B.B.S.				23B. DATE SIGNED 4-20-71		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) HARJIT SINGH M.B.B.S.				23D. ADDRESS 3001 S. HANOVER ST. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/23/71		24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 26 1971		25B. NAME OF REGISTRAR John A. Morap, Inc.		25C. FUNERAL DIRECTOR John A. Morap, Inc.		ADDRESS 3000 E. Baltimore St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4052
BIRTH NO. 1. NAME OF DECEASED (Type or Print) Leo J. Grayson		2. DATE AND HOUR OF DEATH April 23, 1971 1:20 p. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 829 Brooks Lane		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY 1301 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 829 Brooks Lane		
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-15-1899	9. AGE (In years last birthday) 71 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Car Cleaner		10B. KIND OF BUSINESS OR INDUSTRY Pullman Company		
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME James Grayson		14. MOTHER'S MAIDEN NAME Alice ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-16-4566		17. INFORMANT Mrs. Cladie Grayson
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslhenia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertensive Cardic Vascular Disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from Feb. 10 19 71 to Apr. 19 19 71 , that (I) (we) last saw the deceased alive on Apr. 19 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Charles Tommasello M.D.			23B. DATE SIGNED Apr. 26/71	
23C. PHYSICIAN'S NAME (Type) Charles J. Tommasello			23D. ADDRESS 910 W. Lombard Street	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-28-71		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. APR 26 1971		
25B. NAME OF REGISTRAR Blair Kelly		25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME 3035 W. NORTH AVE		



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Leroy Maxfield		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1927 Cecil Ave.		3. DATE PRONOUNCED DEAD Month		Day	Year	Hour	M.
				4	19	71	7:00 p
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland		B. COUNTY 908					
6. SEX male	7. RACE colored	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 3-14-1934	10. AGE (in years last birthday) 37	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John R. Maxfield	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY Maryland Slag Co.		15. MOTHER'S MAIDEN NAME Mildred Johnson			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes Korean War		17. SOCIAL SECURITY NO. 220-30-5718		18. INFORMANT Mrs. Mildred Maxfield			
				ADDRESS 1900 Homewood Ave			
19. CAUSE OF DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Chronic alcoholism							
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:							
(B) DUE TO, OR AS A CONSEQUENCE OF:							
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/20/71							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-23-1971		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 26 1971		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR NUTTER, FUNERAL HOME			
				ADDRESS 3035 W. NORTH AVE			

ACADEMIC BOND

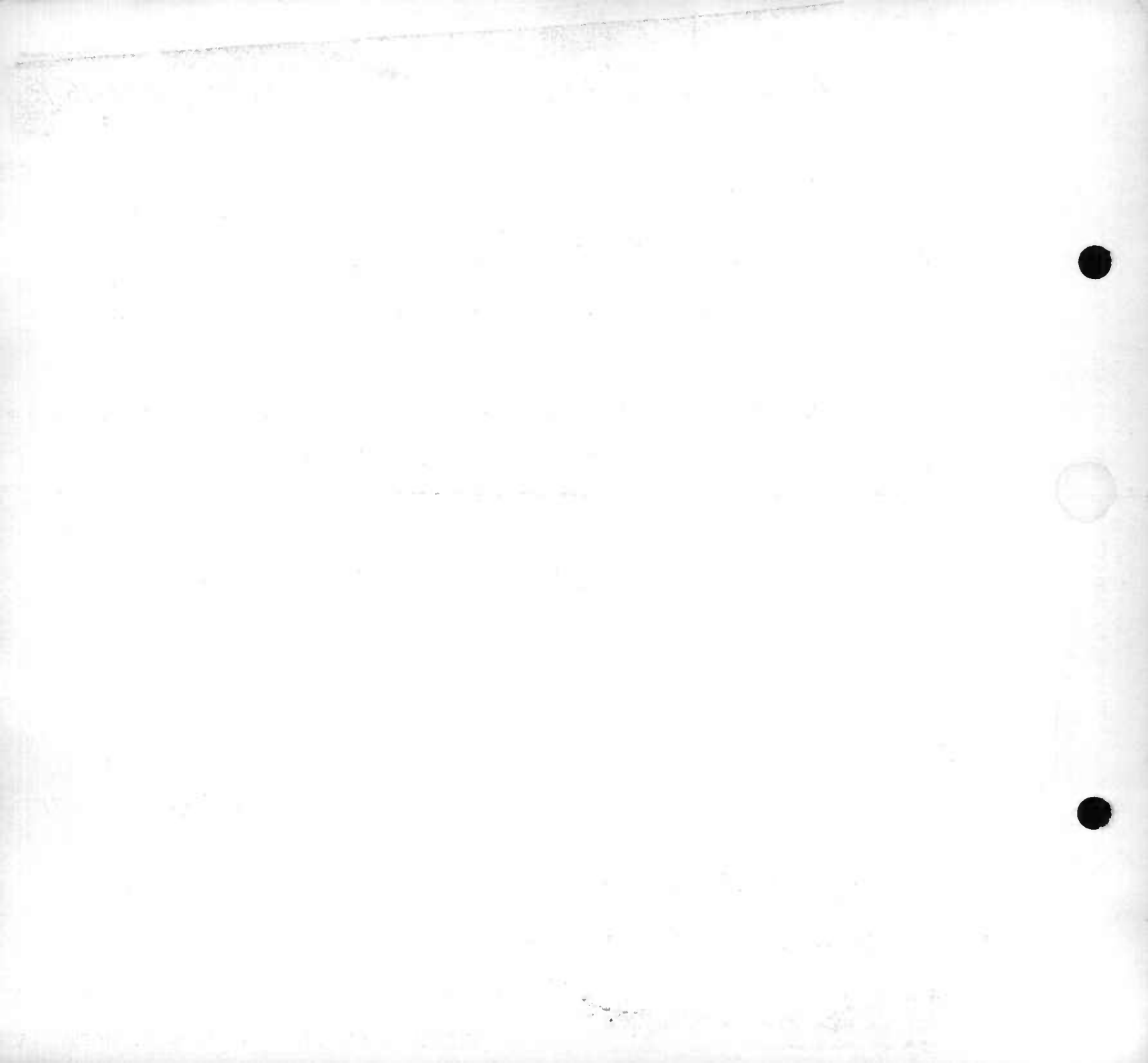
UNIVERSITY OF CALIFORNIA

1964

NAME	DATE
CLASS	TERM
DEPARTMENT	INSTRUCTOR
COURSE	SECTION
STUDENT ID	TEACHER ID
SIGNATURE OF STUDENT	
SIGNATURE OF TEACHER	
DATE	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>71 4054</u>	
J-520 71 4054		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>JAMES O. JONES</u>	
2. DATE AND HOUR OF DEATH <u>25 Apr 71 12:15 P.M.</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)	
4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>1513</u>		C. CITY OR TOWN <u>BALTO.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>2652 PARK HEIGHTS TERR.</u>		5. SEX <u>Male</u> 6. RACE <u>Negro</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10 SEPT 24</u> 9. AGE (In years last birthday) <u>46</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Postal Service</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>? ?</u>		14. MOTHER'S MAIDEN NAME <u>? ?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes World War II</u>		16. SOCIAL SECURITY NO. <u>218-18-8436</u>	
17. INFORMANT <u>Mrs. Virginia G. Jones</u>		ADDRESS <u>2652 Park Heights</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>CARDIOGENIC SHOCK</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>HOURS</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>LUPUS NEPHRITIS</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>MONTHS</u>	
(C) <u>SYSTEMIC LUPUS ERYTHEMATOSUS</u>		<u>YEARS</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>22 APR 1971</u> to <u>25 Apr 1971</u> that (I) (we) last saw the deceased alive on <u>25 APR 1971</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Arthur M. Wagner, M.D.</u>		23B. DATE SIGNED <u>25 APR 71</u>	
23C. PHYSICIAN'S NAME (Type) <u>ARTHUR M. WAGNER, M.D.</u>		23D. ADDRESS <u>SINAI HOSP</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-29-71</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Co. Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 26 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
25C. FUNERAL DIRECTOR <u>NUTTER FUNERAL HOME</u>		ADDRESS <u>3035 W. NORTH AVE</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> B-300 71 4055 </div>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>71 4055</u>	
BIRTH NO. _____ 1. NAME OF DECEASED (Type or Print) <u>Wilson Boyd</u>			2. DATE AND HOUR OF DEATH <u>4/24/71</u> <u>16:00 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Maryland General Hospital</u>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>I</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1504</u> <u>1950 Ridge Hill Ave #17</u>		
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/22/19</u>	9. AGE (In years last birthday) <u>51</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABOR</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME _____			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>200-03-3378</u>		17. INFORMANT <u>Chart</u> ADDRESS _____	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>4/12/71</u> [This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.] ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>			CAUSE OF DEATH <u>Atelectasis</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Subarachnoid Hemorrhage</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Hypertensive cardiovascular disease</u> (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1971</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>April 18</u> 19 <u>71</u> to <u>April 24</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>April 24</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>George C. Samaras</u>			23B. DATE SIGNED <u>4/24/71</u>		
23C. PHYSICIAN'S NAME (Type) <u>GEORGE C. SAMARAS MD</u>			23D. ADDRESS <u>45 BAYSIDE DRIVE Pasadena, MD</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-28-71</u>		24C. NAME of CEMETERY or CREMATORY <u>St. Ambrose Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore MD</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 26 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>	
25C. FUNERAL DIRECTOR <u>Moretown & Jett</u>		25D. ADDRESS <u>1701 Laurens St.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4056	
C-241 71 4056 BIRTH NO. 1. NAME OF DECEASED (Type or Print) James E. Casselberry		CERTIFICATE OF DEATH 2. DATE AND HOUR OF DEATH 4/21/71			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Arbutus D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1216 Oakland Terrace Rd.		5. SEX Male 6. RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 4/1/26 9. AGE (In years last birthday) 45 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk 10B. KIND OF BUSINESS OR INDUSTRY Accounting 11. BIRTHPLACE (State or foreign country) Penn. 12. CITIZEN OF WHAT COUNTRY U. S. A.			
13. FATHER'S NAME Ellsworth Casselberry 14. MOTHER'S MAIDEN NAME Unknown		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII 16. SOCIAL SECURITY NO. 184-24-4766 17. INFORMANT Sheila Casselberry ADDRESS 1216 Oakland Terrace			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH ACUTE CORONARY THROMBOSIS (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CORONARY ARTERY DISEASE (B) DUE TO, OR AS A CONSEQUENCE OF: 10 yr (C)			
19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10/25/1960 to 4/1/1971 that (I) (we) last saw the deceased alive on 4/20/1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Norman R. Kleiman 23B. DATE SIGNED 4/22/71		23C. PHYSICIAN'S NAME (Type) Dr. Norman R. Kleiman 23D. ADDRESS 3809 Edmondson Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 4/24/71 24C. NAME OF CEMETERY OR CREMATORY London Park Cemetery 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. APR 27 1971 25B. NAME OF REGISTRAR John E. Kelly, M.D. 25C. FUNERAL DIRECTOR Ambrose, Inc. 1528 Sulphur Sp. Rd. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
71 4052 CERTIFICATE OF DEATH					REG. NO. 71 4052				
1. NAME OF DECEASED (Type or Print) <i>King, Bertha M</i>					2. DATE AND HOUR OF DEATH <i>4/20/71 4:20 P.M.</i>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2759</i>				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>44 Union Memorial Hospital</i>					C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <i>F</i> 6. RACE <i>W</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <i>4-11-88</i>		9. AGE (In years last birthday) <i>85</i>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>					10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>American</i>
13. FATHER'S NAME <i>EDWIN W. Maddox</i>					14. MOTHER'S MAIDEN NAME <i>Mary Payne</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>212 03 4914B</i>		17. INFORMANT <i>Clart Marion S. King</i>			ADDRESS <i>same</i>	
18. <i>4/12/31</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslhenia, etc. It means the disease, injury or complication which caused death.) <i>Cardiac arrest</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Atherosclerotic heart disease</i> <i>Fever of unknown origin</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION <i>0</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>4/20</i> 19 <i>71</i> to <i>4/20</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>4/20</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>I. Cheikh</i>					23B. DATE SIGNED <i>4/20/71</i>			23C. PHYSICIAN'S NAME (Type) <i>ISSAM E. CHEIKH</i>	
23D. ADDRESS <i>Union Memorial Hospital</i>					23E. MED. Director <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>4/23/71</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Parkwood</i>		24D. LOCATION (City, town, or county) (State) <i>Taylor Ave Balto. Md.</i>		
25A. DATE REC'D BY HEALTH DEPT. <i>APR 27 1971</i>			25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>			25C. FUNERAL DIRECTOR <i>Mitchell Wiedefeld Home 6500 York Rd.</i>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 4058</u>	
BIRTH NO. <u>H-500 71 4058</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Mrs. Sara Cull Hume</u>			2. DATE AND HOUR OF DEATH <u>4-20-71</u> <u>3-40-P.M.. M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>91 Keswick</u> <u>700 West 40th. Street</u> <u>Baltimore, Md. 21211</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>14-01</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>700 W. 40TH. STREET</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-6-1883</u>	9. AGE (In years last birthday) <u>87</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country) <u>Moreland</u> <u>Frederick County, Md.</u>	
13. FATHER'S NAME <u>Roger W. Cull</u>			14. MOTHER'S MAIDEN NAME <u>Evelyn White</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>118-36-9343</u>		
17. INFORMANT <u>Keswick Records</u>			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Pneumonia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Emphysema</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>Years</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>ASCVD</u>			<u>Year</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>2-3</u> 19 <u>69</u> to <u>4-20</u> 19 <u>71</u> , that (I) (we) lost saw the deceased alive on <u>4-20</u> 19 <u>71</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>RK Gundry</u> M.D.				23B. DATE SIGNED <u>4-21-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>RK GUNDRY</u>				23D. ADDRESS <u>2W University Pkwy - 71218</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>BURIAL 4/2/71</u>		24C. NAME of CEMETERY or CREMATORY <u>MT. OLIVET CEMETERY</u>	
24D. LOCATION (City, town, or county) (State) <u>FREDERICK MD.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 27 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>MITCHELL-WIEDEFELD 6500 YORK RD</u>			

6-253

71 4059

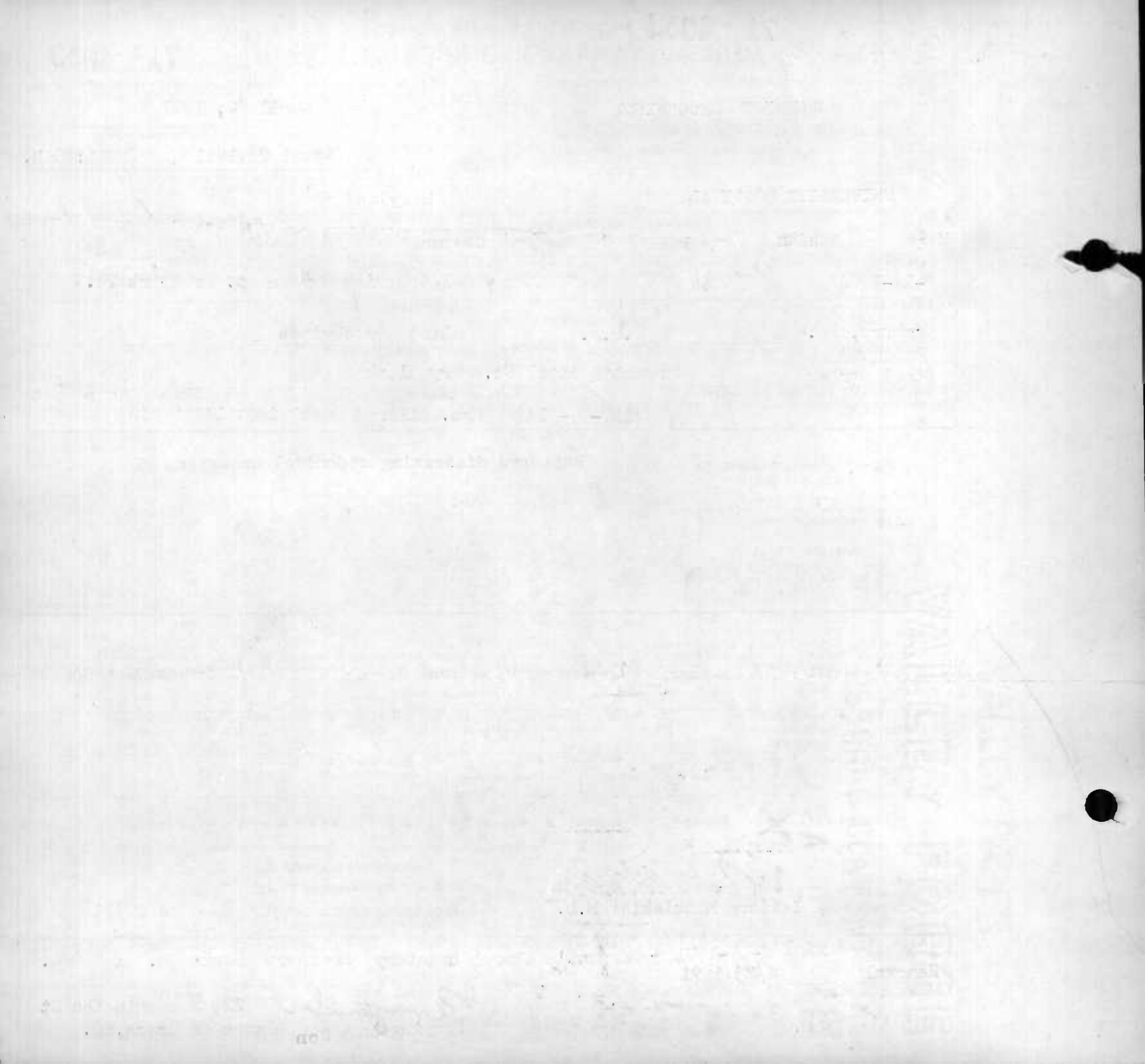
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 4059

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FREDERICK GESCHWINDT		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month April Day 22 , Year 1971 Estimated <input type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY HOSPITAL		3. DATE PRONOUNCED DEAD Month April Day 22 , Year 1971 11:15 P.M.	
6. SEX Male 7. RACE White 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 21-005	
9. DATE OF BIRTH 8-12-1904 10. AGE (In years last birthday) 66 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		C. CITY OR TOWN Easton D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) Hamburg, Pa. 12. CITIZEN OF WHAT COUNTRY? U.S.A.		E. STREET AND NUMBER ? 145 Spring Garden St. Leesport Pa.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel worker 14B. KIND OF BUSINESS OR INDUSTRY Carpenter Steel Co.		15. MOTHER'S MAIDEN NAME Mary Blank	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 187-09-8143 18. INFORMANT Mrs. Mildred Geschwindt ADDRESS Leesport, Pa. 145 Spring Garden St.	
19. 441.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH Ruptured dissecting abdominal aneurysm (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 4-23-1971 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Isidore Mihalakis, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 4/23/71 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION: REMOVAL (Specify) Removal 24B. DATE 4-27-1971		24C. NAME OF CEMETERY or CREMATORY Gernant's Church cemetery 24D. LOCATION (City, town, or county) (State) Leesport Berks Co. Pa.	
25A. DATE REC'D BY HEALTH DEPT. APR 27 1971 25B. NAME OF REGISTRAR John E. Fisher, M.D.		25C. FUNERAL DIRECTOR Pennington & Son ADDRESS 225 S Washington St Havre de Grace, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 4060</u>	
BIRTH NO. <u>Q-240</u>		71 4060			
1. NAME OF DECEASED (Type or Print) <u>QUICKLEY RICHARD</u>		2. DATE AND HOUR OF DEATH <u>April 25th 1971</u> <u>7:10 P.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>39 Provident Hospital, Inc.</u> <u>2600 Liberty Heights Avenue</u> <u>Baltimore, Maryland 21215</u>		A. STATE <u>Maryland</u> B. COUNTY <u>1402</u>			
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>1416 Myrtle Avenue</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-23-23</u>	9. AGE (In years last birthday) <u>47</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>National Floor and Ceiling</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME			
14. MOTHER'S MAIDEN NAME <u>Sarah Quickley</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>217-18-9739</u>		17. INFORMANT <u>Mrs. Minnie Jane Quickley</u>		ADDRESS <u>Same</u>	
18. <u>13411</u> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Respiratory and Central Failure.</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Post-op Stricture Small Int.</u>		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) <u>Case of Ca. Roctum operated.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>4-24-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Gr. Hemorrhoids</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>(4/1/71)</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>4/25/71</u> to <u>4/25/71</u> 19 <u>71</u> and that (I) (we) last saw the deceased alive on <u>4/25/71</u> 19 <u>71</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
22A. SIGNATURE <u>[Signature]</u>		22B. DATE SIGNED <u>4/28/71</u>		23A. PHYSICIAN'S NAME (Type) <u>DR. Y. BANURAI</u>	
23B. ADDRESS <u>PROVIDENT HOSPITAL; BALTIMORE</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>B</u>			
24B. DATE <u>4-28-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>MT. Auburn</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 27 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Sullivan Funeral Home</u>	
ADDRESS <u>11011-131</u>					

Office of the
Director of the
Bureau of the
Census

Washington, D.C.
20540

1970-1971

1970-1971

1970-1971

1970-1971

1970-1971

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

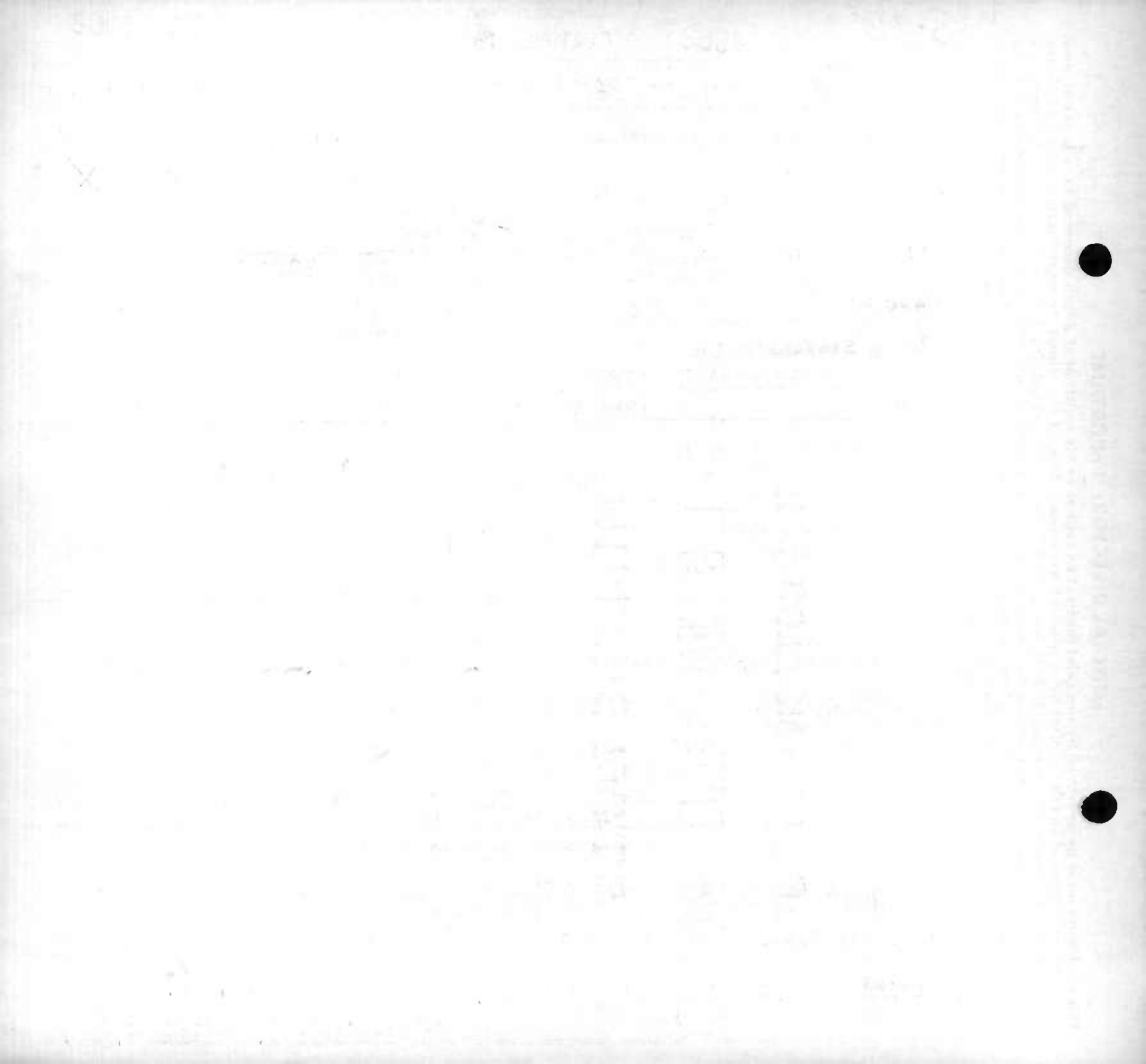
P-620 71 4061		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 4061	
1. NAME OF DECEASED (Type or Print) <i>Harry B. Price</i>		2. DATE AND HOUR OF DEATH <i>4-22-71 8:40 A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2741</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>42 Sinai Hospital & Baltimore</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>6541 Biddison LA</i>			
5. SEX <i>M</i>	6. RACE <i>A</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-15-88</i>	9. AGE (In years last birthday) <i>82</i>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Insurance Ag.</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Confidential</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>	
12. CITIZEN OF WHAT COUNTRY? <i>US</i>		13. FATHER'S NAME <i>James Price</i>			
14. MOTHER'S MAIDEN NAME <i>Virginia Zimmermann</i>		15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service) <i>—</i>			
16. SOCIAL SECURITY NO. <i>212-07-2937</i>		17. INFORMANT <i>Wife</i> ADDRESS <i>Same</i>			
18. <i>4-10-91</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary Block</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Acute myocardial infarction</i> (C) DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerotic Heart Disease</i>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Pneumonia</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Indify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (at) this hospital attended the deceased from <i>4-19</i> 19 <i>71</i> to <i>4-22</i> 19 <i>71</i> that (it) (we) last saw the deceased alive on <i>4-22</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (it) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Rodolph S. Victoria MD</i>		23B. DATE SIGNED <i>4-22-71</i>		23C. PHYSICIAN'S NAME (Type) <i>Rodolfo S. Victoria MD</i>	
23D. ADDRESS <i>Sinai Hospital of Baltimore</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			
24B. DATE <i>4/26/71</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Greenwood Cem</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore</i>	
25A. DATE RECEIVED BY HEALTH DEPT. <i>APR 27 1971</i>		25B. NAME OF REGISTRAR <i>John E. ...</i>		25C. FUNERAL DIRECTOR <i>J. Zimmermann 6067 Harford</i>	



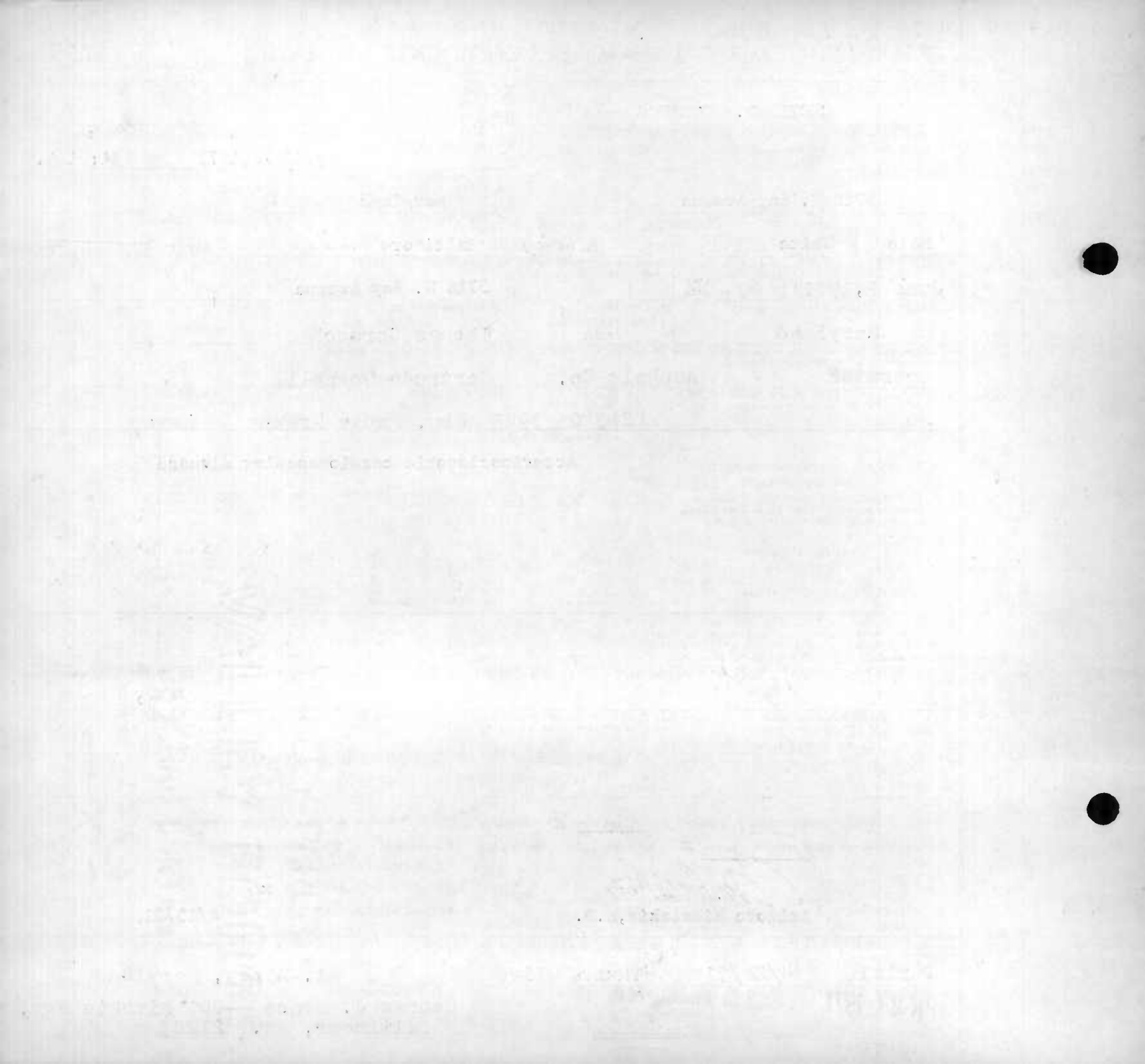
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH									
REG. NO. 71 4062									
BIRTH NO. S-315		71 4062		Stephan					
1. NAME OF DECEASED (Type or Print) WILLIAM STEFANKIEWICZ						2. DATE AND HOUR OF DEATH April 22, 1971 12:05 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY A.A.C.D.			
FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General Hospital						C. CITY OR TOWN PASADENA		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)						E. STREET AND NUMBER 8483 Swaine Ave.			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-24-28	9. AGE (In years last birthday) 42 yrs	10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10B. KIND OF BUSINESS OR INDUSTRY US Army		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Stefankiewicz				14. MOTHER'S MAIDEN NAME Maury Friedman					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service Yes				16. SOCIAL SECURITY NO. 21.6 24 641.8		17. INFORMANT Swaine Stefankiewicz (wife)		ADDRESS SAME	
18. 410.9 I CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiogenic shock (B) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION O			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from April 21 19 71 to April 22 19 71 that (I) (we) last saw the deceased alive on April 22 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Virginia Faust - Mercado, M.D.						23B. DATE SIGNED 4-22-71			
23C. PHYSICIAN'S NAME (Type) VIRGINIA FAUSTO - MERCADO, M.D.						23D. ADDRESS South Baltimore General Hospital			
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 4/26/71		24C. NAME of CEMETERY or CREMATORY Glen Haven Mem. Pk.		24D. LOCATION (City, town, or county) (State) Glen Burnie, Md.			
25A. DATE RECEIVED BY HEALTH DEPT. APR 27 1971		25B. NAME OF REGISTRAR John E. Smith, Jr.		25C. FUNERAL DIRECTOR George J. Gonce Funeral Home		ADDRESS 4001 Ritchie Hwy. Baltimore, Md.			



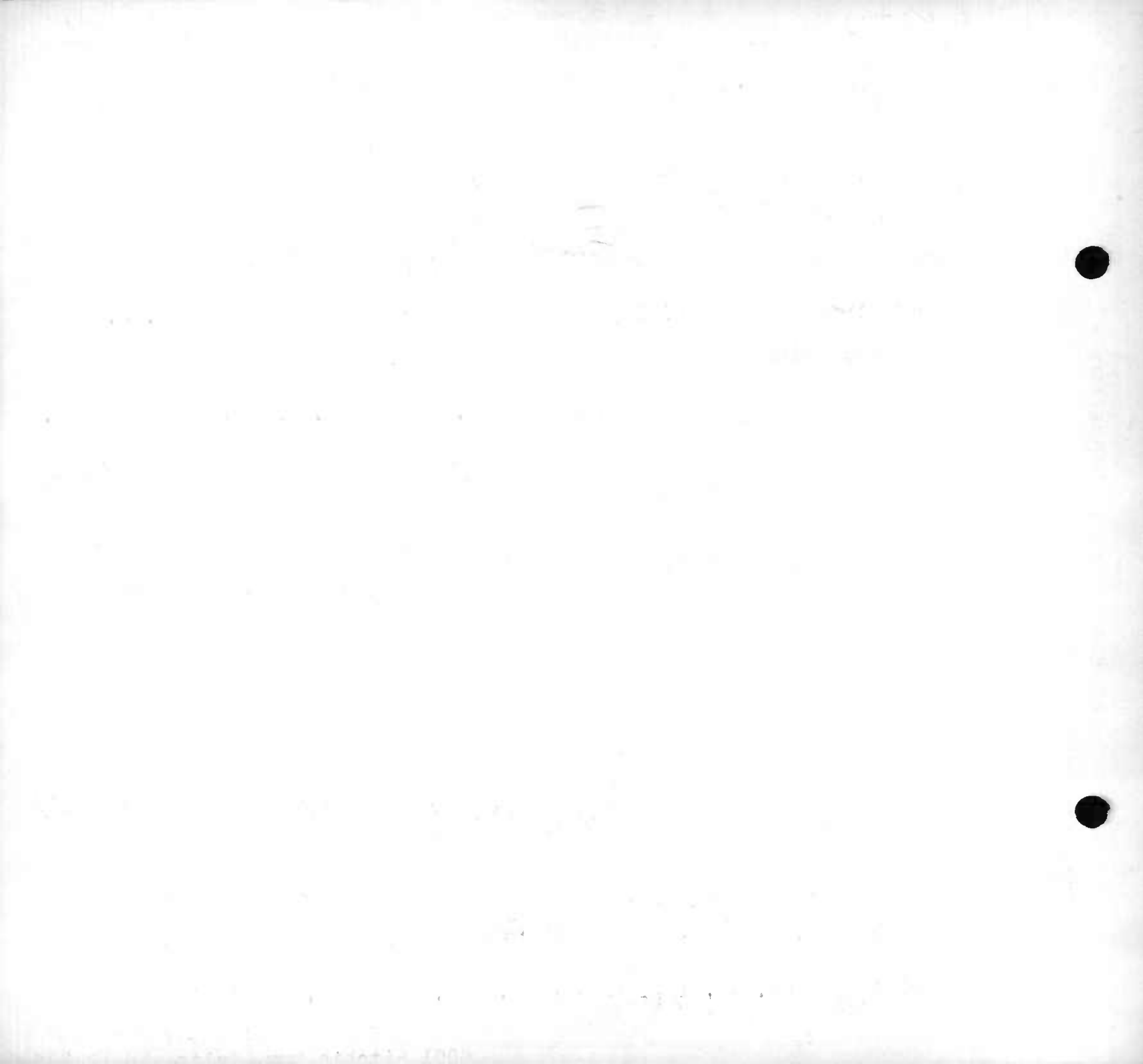
BALTIMORE CITY HEALTH DEPARTMENT		71 4063	
G-622 71 4063		MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) CECIL T. GORSUCH		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3718 W. Bay Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour April 23, 1971 11:21 A.M.	
6. SEX Male		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2505	
7. RACE White		C. CITY OR TOWN Baltimore	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH June 1, 1901		E. STREET AND NUMBER 3718 W. Bay Avenue	
10. AGE (In years last birthday) 69 XM			
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Gorsuch			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		15. MOTHER'S MAIDEN NAME Gertrude Gosnell	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 213 05 3925	
18. INFORMANT Mrs. Madge Kroupa		ADDRESS Same	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		21. AUTOPSY? (Yes or No) no	
20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
		DATE SIGNED 4/23/71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/26/71	
24C. NAME OF CEMETERY or CREMATORY Mount Olive		24D. LOCATION (City, town, or county) (State) Mt. Airey, Maryland	
25A. DATE RECEIVED BY HEALTH DEPT. APR 27 1971		25B. NAME OF REGISTRAR George J. Gonce	
		25C. FUNERAL DIRECTOR ADDRESS 4001 Ritchie Hgy. Baltimore, Md. 21225	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4064	
K-520 71 4064				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Jasper H. King</u>		2. DATE AND HOUR OF DEATH <u>April 24, 1971</u> <u>8:45</u> <small>M.</small>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Harbor View Nursing Home</u> <u>90 1213 Light St.</u>		A. STATE <u>MD</u>		B. COUNTY <u>Balto City</u> <u>2544</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Balto</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>4115 Hague Ave</u>			
5. SEX <u>Male</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/5/87</u>	9. AGE (in years last birthday) <u>82</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coal Miner</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Mining</u>		11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>	
13. FATHER'S NAME <u>Henry King</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>927-22-4997</u>		17. INFORMANT <u>Mr. Charles L. King</u> <u>4115 Hague Ave.</u>	
18. <u>492X1</u>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pneumonia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4/20/71</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>yes</u>	
		(C) <u>Arteriosclerosis generalized</u>		<u>yes</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/29</u> 19 <u>69</u> to <u>4/24</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>4/21</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>ALAN H. MAECHT MD</u>		23B. DATE SIGNED <u>4/25/71</u>		23C. PHYSICIAN'S NAME (Type) <u>ALAN H. MAECHT MD</u>	
23D. ADDRESS <u>2 E Read St</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>Apr. 28, 1971</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Ida Bapt. Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Ida, Virginia</u>	
25A. DATE RECEIVED HEALTH DATA <u>APR 27 1971</u>		25B. NAME OF REGISTRAR <u>Jabed E. Bailey</u>		25C. FUNERAL DIRECTOR <u>Donce Funeral Home</u>	
				ADDRESS <u>4001 Ritchie Hwy Balto Md 21225</u>	



BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LINDA KUSICK

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
(If not in hospital or institution, give street address or location)

43 SOUTH BALTO. GENERAL HOSPITAL

6. SEX

Female

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

9. DATE OF BIRTH

Nov. 1, 1954

10. AGE (In years last birthday)

16

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

USA

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Student

14B. KIND OF BUSINESS OR INDUSTRY

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

18. INFORMANT

George Kusick

ADDRESS

Same

E812.1

CAUSE OF DEATH

Multiple Injuries

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)
Street

22C. WHERE DID (If in Baltimore City, give exact location)

INJURY OCCUR? 2500 blk. of Hawkins Pt. Rd. near
entrance of Coast Guard Yard.22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.) 4-24-71 2:10 A. M.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Passenger in auto struck in rear by other
car and struck utility pole.

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S NAME (Type) Werner U. Spitz, M.D.

Deputy
M.D.CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/24/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4/27/71

24C. NAME OF CEMETERY or CREMATORY

Glen Haven Mem. Pk.

24D. LOCATION (City, town, or county) (State)

Glen Burnie, Md.

25A. DATE REC'D BY HEALTH DEPT.

APR 27 1971

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

George J. Gonce 4001 Ritchie Hwy.
Baltimore, Md. 21225

ADDRESS

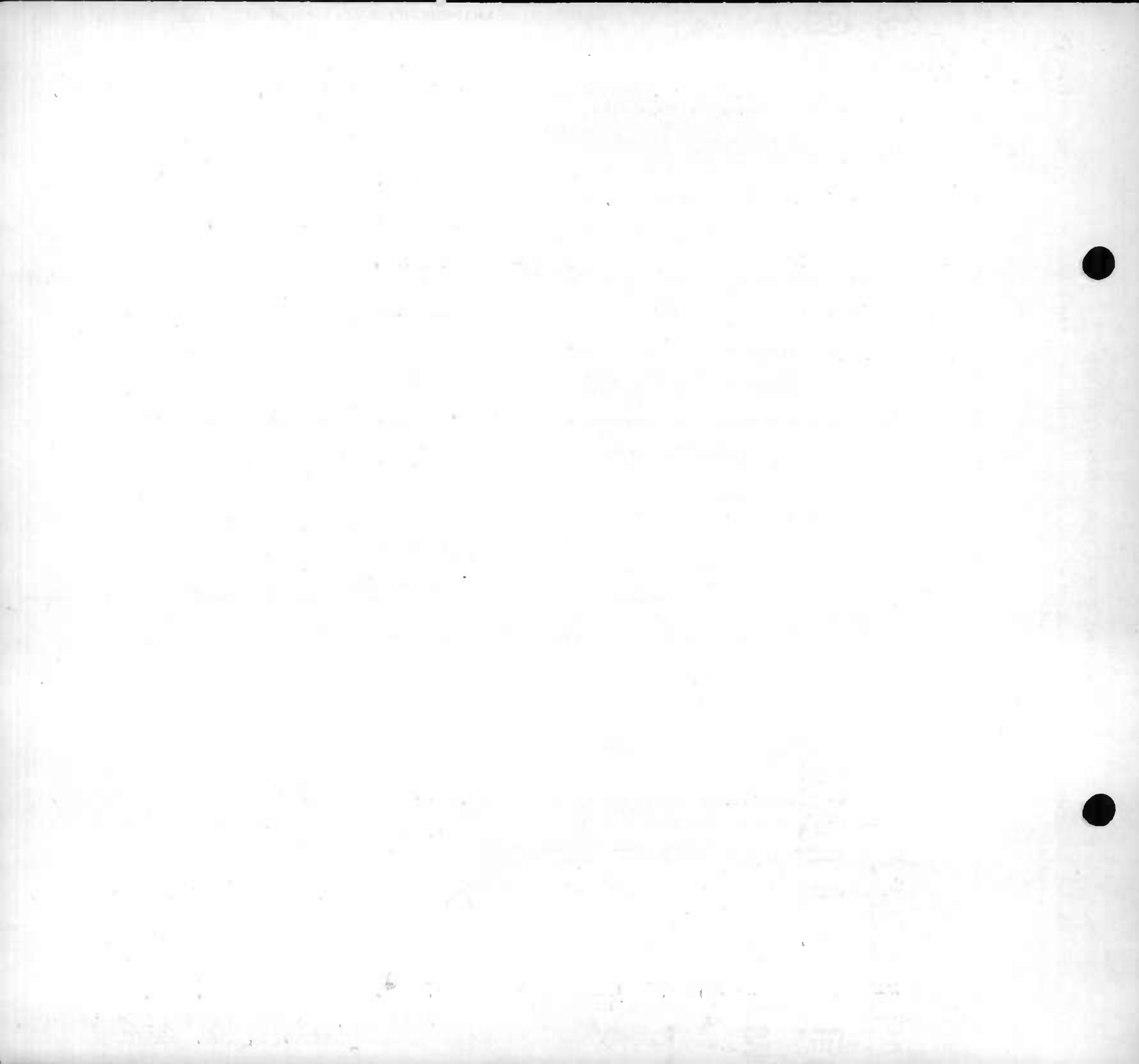
CADREX REGION

Brill

FUNERAL DIRECTOR: IMPORTANT

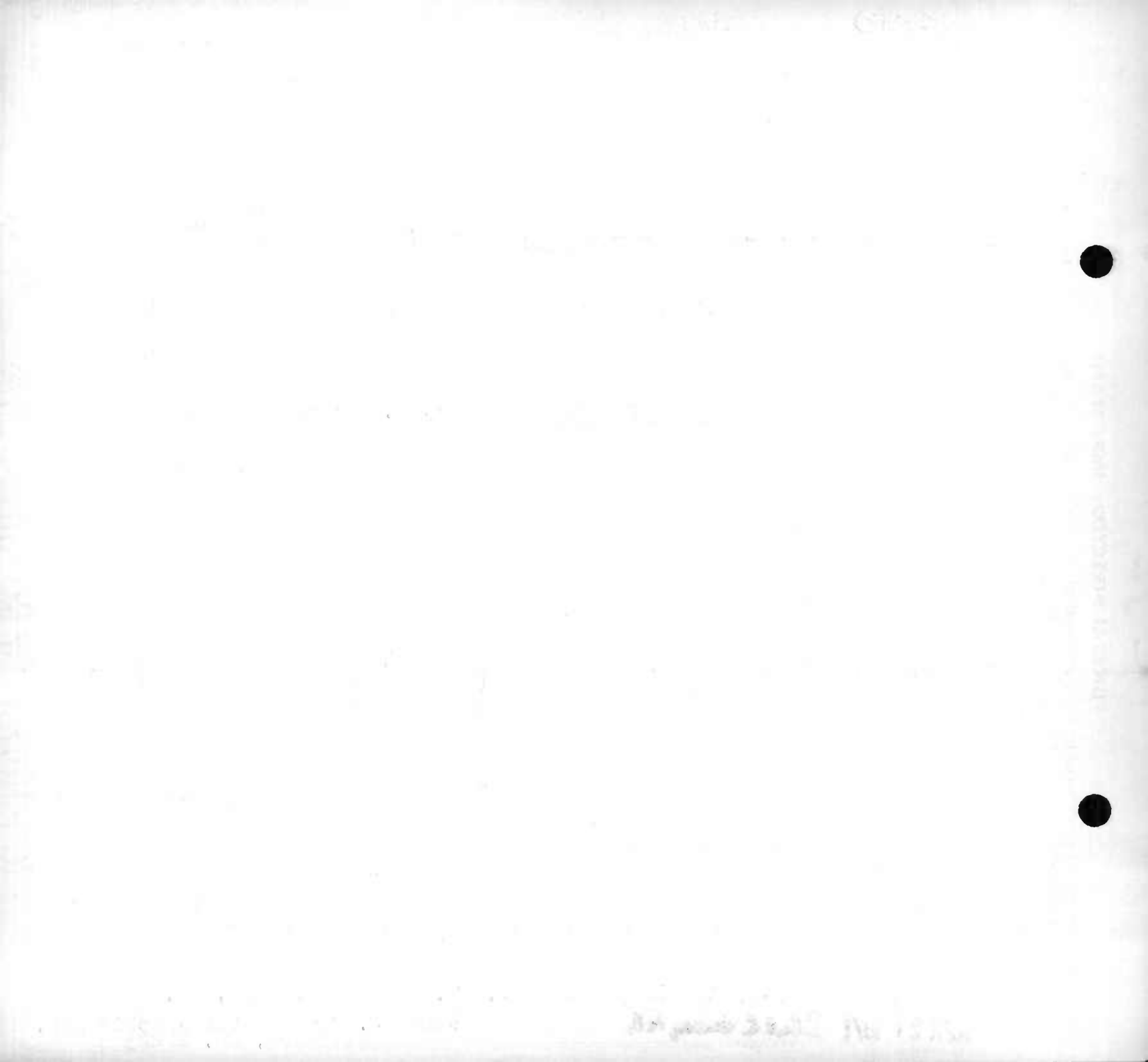
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 4066
BIRTH NO. H-240 71 4066		2. DATE AND HOUR OF DEATH April 22, 1971 2:00 P. M.		
1. NAME OF DECEASED (Type or Print) NANNIE JANE HASSELL		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2201. Curtis Creek Rd.		
4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 2505		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX Female		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH April 23, 1906		9. AGE (In years last birthday) 64 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Addison Johnson		
14. MOTHER'S MAIDEN NAME Bathgate		15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Leroy Hassell		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslhenia, etc. It means the disease, injury or complication which caused death.) 492 X I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNOERLYING CONOITION last. II		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cor pulmonale (B) DUE TO, OR AS A CONSEQUENCE OF: Pulmonary emphysema and fibrosis (C) Granulomata of liver		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Nat White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from June 24 1958 to April 22 1971 , that (I) (we) last saw the deceased alive on April 12 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE Morton Kreiger		23B. DATE SIGNED April 24, 1971		23C. PHYSICIAN'S NAME (Type) Dr. Morton Kreiger
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE April 26, 1971		24C. NAME of CEMETERY or CREMATORY Glen Haven Mem. Pk.
24D. LOCATION (City, town, or county) (State) Glen Burnie, Md.		25A. DATE REC'D BY HEALTH DEPT. APR 27 1971		
25B. NAME OF REGISTRAR Robert E. Fisher, Jr.		25C. FUNERAL DIRECTOR George J. Gonce		
25D. ADDRESS 4001 Ritchie Hgy. Baltimore, Md. 21225				



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

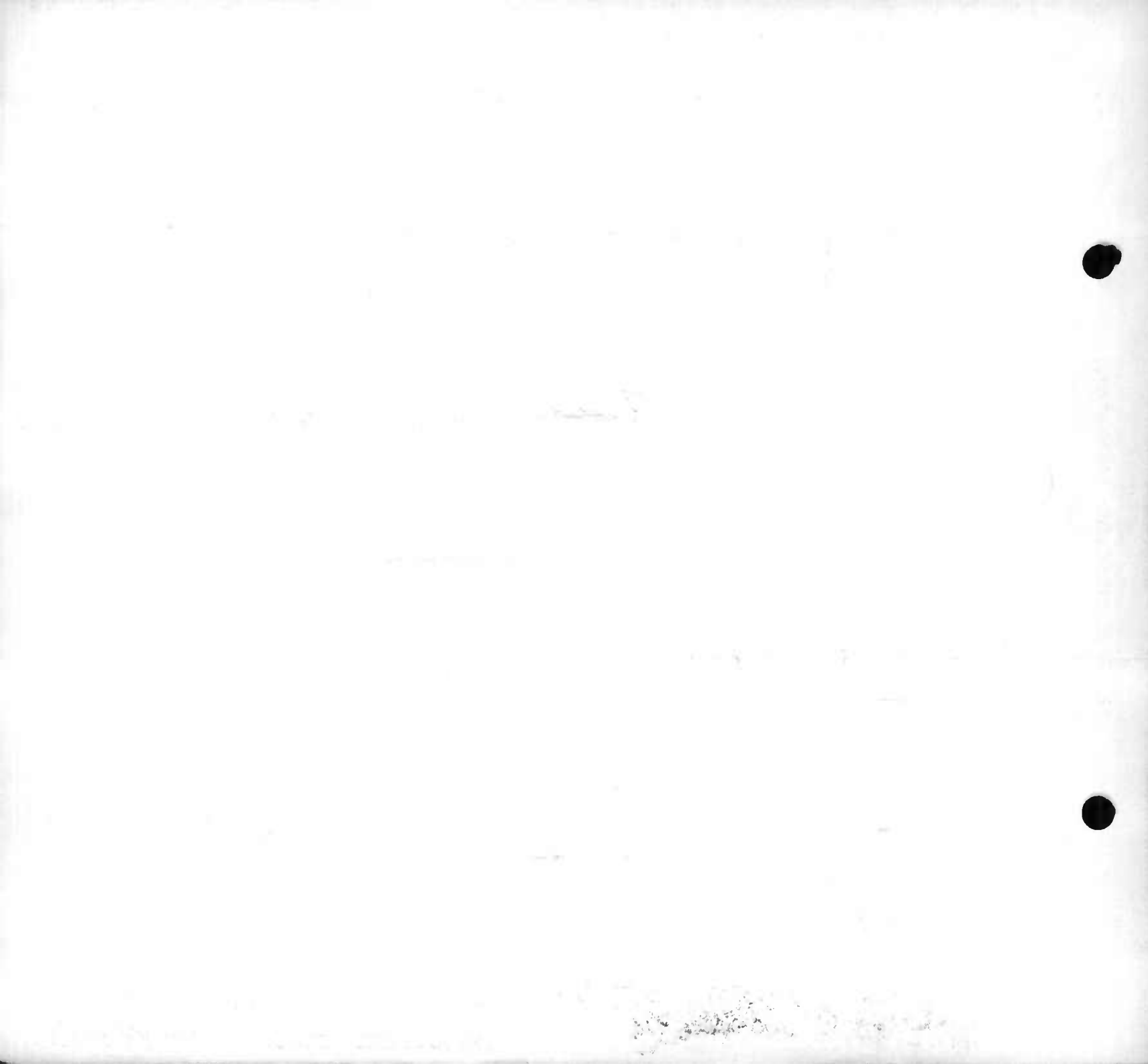
<p>K-250 71 4067</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 71 4067</p>	
<p>BIRTH NO. _____</p>		<p>1. NAME OF DECEASED (Type or Print) ROBERT THOMAS KEEGAN</p>	
<p>2. DATE AND HOUR OF DEATH 4-20-71 9:00A M.</p>		<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION 43 SOUTH BALTIMORE GEN. HOSPITAL</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2544</p>	
<p>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p>		<p>C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>E. STREET AND NUMBER 927 PONTIAC AVE.</p>		<p>5. SEX M 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	
<p>8. DATE OF BIRTH 10-12-1915 9. AGE (In years last birthday) 55</p>		<p>If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHIP FITTER</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY Coast Guard</p>	
<p>11. BIRTHPLACE (State or foreign country) MARYLAND</p>		<p>12. CITIZEN OF WHAT COUNTRY? USA</p>	
<p>13. FATHER'S NAME JOSEPH KEEGAN</p>		<p>14. MOTHER'S MAIDEN NAME HELEN THOMAS</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No</p>		<p>16. SOCIAL SECURITY NO. 215 09 7109</p>	
<p>17. INFORMANT Mary E. Keegan ADDRESS Same</p>		<p>18. 201X I CAUSE OF DEATH</p>	
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p>		<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: HODGKIN'S DISEASE</p>	
<p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(B) DUE TO, OR AS A CONSEQUENCE OF: SEVERE ANEMIA</p>	
<p>(C) _____</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION 0</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No)</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from 4-20-71 to 4-20-71 that (I) (we) last saw the deceased alive on 4-20-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE Gaudencio A. Arriaga M.D.</p>		<p>23B. DATE SIGNED 4-20-71</p>	
<p>23C. PHYSICIAN'S NAME (Type) GAUDENCIO A. ARRIAGA</p>		<p>23D. ADDRESS SOUTH BALTIMORE GEN HOSPITAL</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 4/23/71</p>	
<p>24C. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.</p>		<p>24D. LOCATION (City, town, or county) (State) Glen Burnie, Md.</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. APR 27 1971</p>		<p>25B. NAME OF REGISTRAR Robert E. Taylor, M.D.</p>	
<p>25C. FUNERAL DIRECTOR George J. Gonce</p>		<p>ADDRESS 4001 Ritchie Hgy. Baltimore, Md. 21225</p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> N-242 71 4068 BALTIMORE CITY HEALTH DEPARTMENT X 71 4068 </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>			
1. NAME OF DECEASED (Type or Print) GEORGE C. NICHOLS JR		2. DATE AND HOUR OF DEATH APRIL 22 1971 4 45 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 UNIV. OF MARYLAND HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY CALVERT C. CITY OR TOWN HENRYTON STATE HOSPITAL D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER HENRYTON STATE HOSPITAL	
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/19/23
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY —	9. AGE (In years last birthday) 47
11. BIRTHPLACE (State or foreign country) ? MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S	
13. FATHER'S NAME G. CASHELL NICHOLS		14. MOTHER'S MAIDEN NAME GLADYS ANDERSON	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 7-2-2-2-2-2-2-2-2-2	
17. INFORMANT G. Casshell Nichols SR. Elliott Pk. Md 21043		ADDRESS 9954 OAKLEA CT.	
18. 595.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ACUTE HEPATIC FAILURE (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. RENAL FAILURE 2° to (A) AORTIC STENOSIS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 DAYS 2 DAYS YRS	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION 2/20/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/2 19 71 to 4/22 19 71 that (I) (we) last saw the deceased alive on 4/22 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do) view the body after death.			
23A. SIGNATURE Meyer R. Heyman M.D.		23B. DATE SIGNED 4/22/71	
23C. PHYSICIAN'S NAME (Type) MEYER R. HEYMAN M.D.		23D. ADDRESS Highland Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-25-71	
24C. NAME of CEMETERY or CREMATORY ST. MARKS		24D. LOCATION (City, town, or county) (State) Highland Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 27 1971		25B. NAME OF REGISTRAR Robert E. Taylor JR	
25C. FUNERAL DIRECTOR Higginbottom - Slack		ADDRESS Elliott Pk. Md 21043	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 4069

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN WILLIAMS		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Parking Lot-207 N. Calvert Street		3. DATE PRONOUNCED DEAD April 23, 1971		Month	Day	Year	Hour 4:00 P.
6. SEX Male		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Dec. 20, 1929		10. AGE (In years lost birthday) 41		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		14B. KIND OF BUSINESS OR INDUSTRY Building		13. FATHER'S NAME Luke T. Williams		15. MOTHER'S MAIDEN NAME Anna E. Forrest	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 216 24 9218		18. INFORMANT Mrs. Anna E. Williams		ADDRESS Same	
19. E957X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Multiple Injuries		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) _____ (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Building		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 207 N. Calvert Street		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 4-23-71 3:50 P.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Jumped from Court Square Building					
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. EXAMINER'S NAME (Type) DATE SIGNED 4/24/71							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/27/71		24C. NAME OF CEMETERY or CREMATORY St. Michaels		24D. LOCATION (City, town, or county) (State) Leonardtown, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 27 1971		25B. NAME OF REGISTRAR Robert E. Fisher, R.D.		25C. FUNERAL DIRECTOR George J. Gonce		ADDRESS 4001 Ritchie Hvy. Baltimore, Md. 21225	

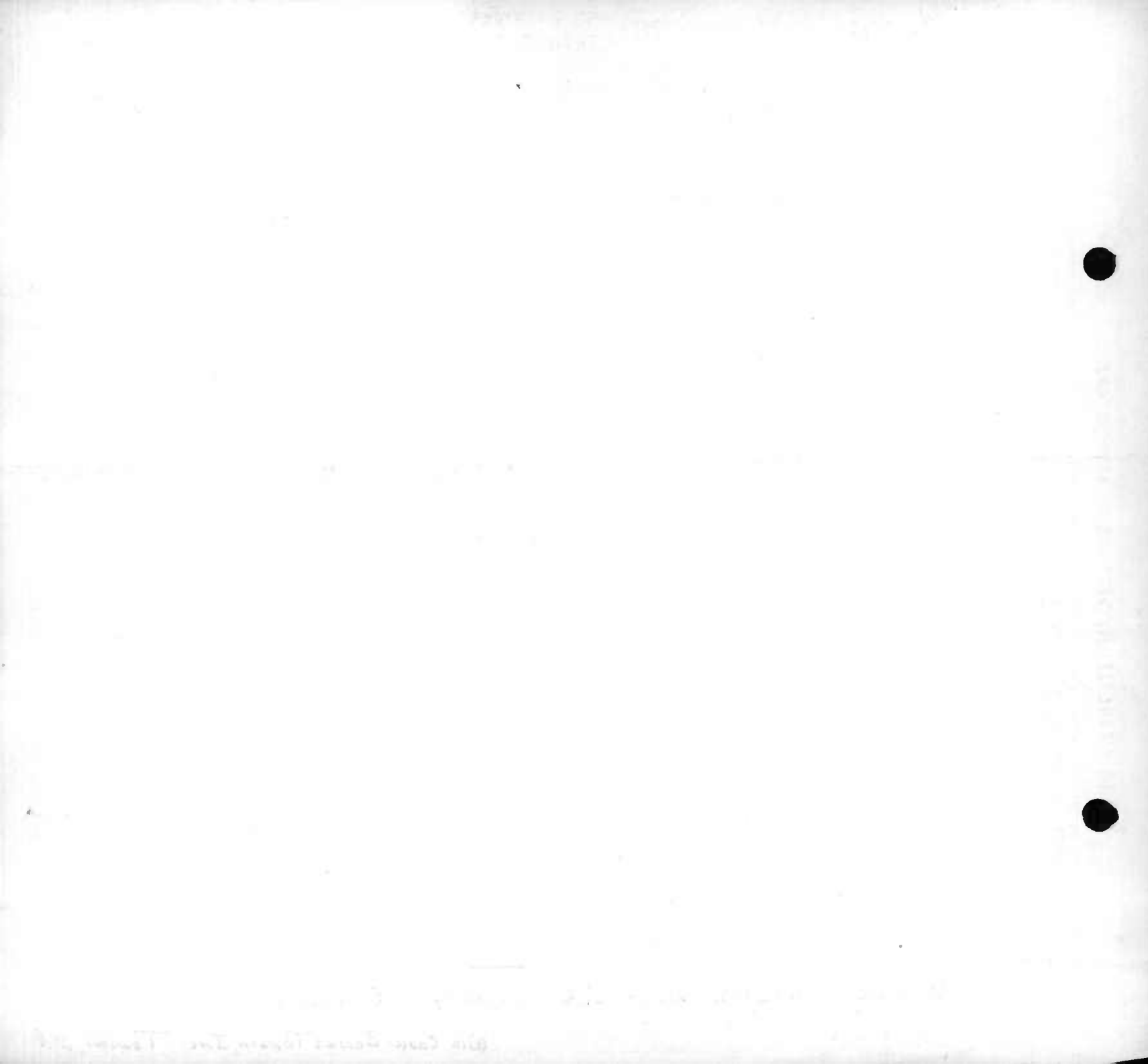
SCARLETT PETERSON

1/10/1911

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

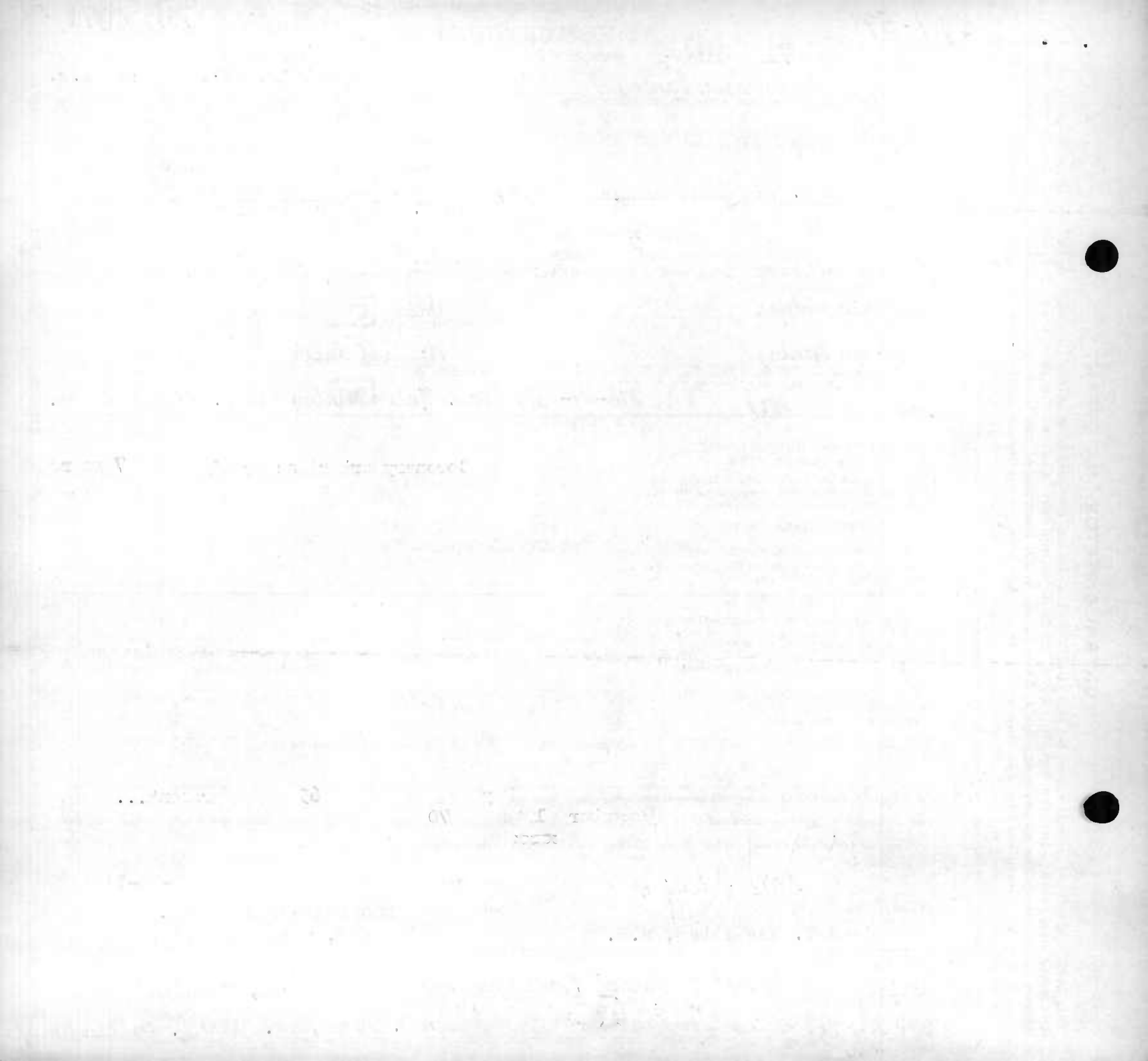
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4070
BIRTH NO. 1. NAME OF DECEASED (Type or Print) JOSEPH W. MILLER		2. DATE AND HOUR OF DEATH 4-23-1971 2 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CHURCH HOME AND HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 202 5. CITY OR TOWN BALTIMORE 6. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 7. STREET AND NUMBER 25 S. BROADWAY		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 6, 1917 9. AGE (in years last birthday) 53 10. UNDER 1 Yr. Months 11. UNDER 24 Hrs. Days	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER		10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Wythville U.A. 12. CITIZEN OF WHAT COUNTRY? American		
13. FATHER'S NAME Joseph K. Miller		14. MOTHER'S MAIDEN NAME Amie Sheffy		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 229-05-8367		17. INFORMANT ADDRESS
18. CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 HRS. 3 YEARS.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). EMPHYSEMA AND CIRRHOSIS OF THE LIVER				UNKNOWN
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 4-22-71 to 4-23-71 that (I) (we) last saw the deceased alive on 4-23-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Rustum. Irani MD				23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) RUSTUM IRANI MD				23D. ADDRESS CHURCH HOME AND HOSPITAL
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-27-71		24C. NAME OF CEMETERY OR CREMATORY WEST END CEMETERY
24D. LOCATION (City, town, or county) (State) Wythville VA.		25A. DATE REC'D BY HEALTH DEPT. APR 27 1971		
25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR Wm. Cook-Briggs Towson, Inc. Towson, Md.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4071	
<div style="display: flex; justify-content: space-between;"> M-540 71 4071 </div>					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Leo Burton Manley		✓ April 22, 1971 1:15 a.m. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION			A. STATE B. COUNTY		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			Maryland 2610		
00 16 N. Highland Avenue			C. CITY OR TOWN D. INSIDE CITY LIMITS?		
			Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER		
			16 N. Highland Avenue		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	6/21/'20	50	Electric Welder
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
			Ohio		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
George Manley			Mildred Smith		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
yes WW11			218-09-7577		Mrs. Helen Manley 16 N. Highland Ave.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Coronary arteriosclerosis 7 years		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from May 1965 to present... 19... that (I) (we) last saw the deceased alive on December 17th 1970 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
John B. MacGibbon, M.D.				4-23-71	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
John B. MacGibbon, M.D.				800 Cathedral Street Baltimore, Maryland 21201	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		4/26/'71		Sacred Heart Cemetery	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 27 1971		Robert E. Bailey, M.D.		John A. Moran, Inc. 3000 E. Baltimore St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

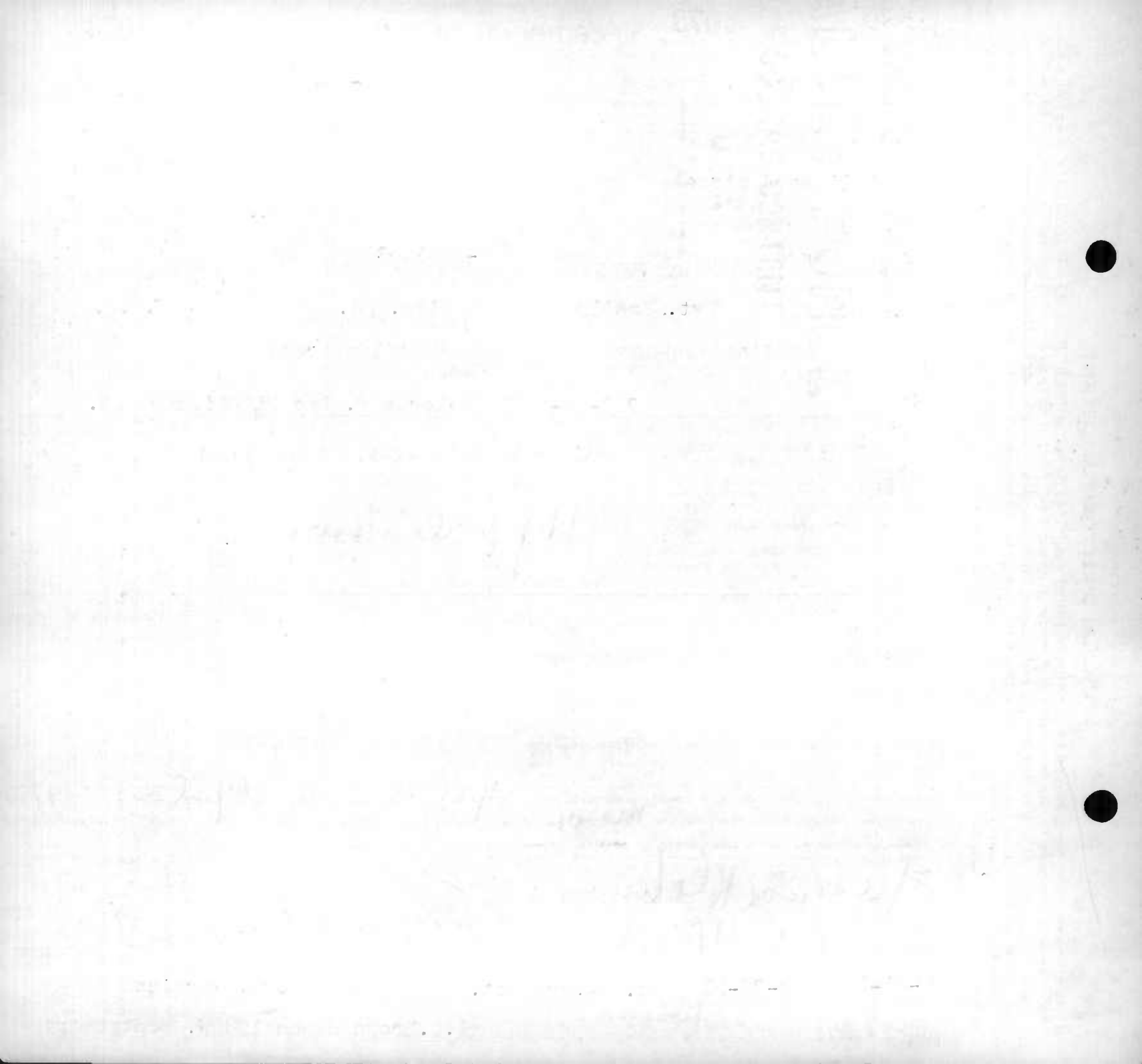
B-600				71 4072		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 4072	
1. NAME OF DECEASED (Type or Print) <u>Marie V. Berry</u>						2. DATE AND HOUR OF DEATH <u>April 16, 1971</u> <u>11:45 PM</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Good Samaritan Hosp.</u> <u>45</u>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		A. STATE <u>MARYLAND</u>		B. COUNTY <u>1101</u>			
				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER <u>534 N. CHARLES ST. Apt 1506</u>					
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>04-24-93</u>		9. AGE (In years last birthday) <u>77</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>business firm</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Edward Berry</u>				14. MOTHER'S MAIDEN NAME <u>Emelie Packner</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-09-0655</u>		17. INFORMANT <u>Doris Mueker</u>		ADDRESS <u>Sanage Md</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>2001 I</u>						CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pneumonia</u>		<u>24 hours</u>	
						(B) <u>Lymphosarcoma, generalized</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>18 months</u>	
						(C) _____		_____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Cytotoxic treatment for lymphoma</u>						<u>2 months</u>			
19A. DATE OF OPERATION <u>0</u> none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>xxx</u>		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>xxx</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>no</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>xxx</u>		21C. WHERE DID INJURY OCCUR? <u>xxx</u>		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>xxx</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (H) (this hospital) attended the deceased from <u>March 5,</u> 19 <u>71</u> to <u>April 16,</u> 19 <u>71</u> that (I) (we) lost saw the deceased alive on <u>April 16,</u> 19 <u>71</u> and that (in) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>George H. Sack, Jr.</u>						23B. DATE SIGNED <u>April 16, 1971</u>			
23C. PHYSICIAN'S NAME (Type) <u>George H. Sack, Jr., M.D.</u>				23D. ADDRESS <u>5600 Loch Raven Blvd., Balto. Md., 2121</u>					
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		24B. DATE <u>4/20/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Madamridge Green Park</u>		24D. LOCATION (City, town, or county) (State) <u>Dorsey Md</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 27 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Sack, M.D.</u>		25C. FUNERAL DIRECTOR <u>Donaldson JH</u>		ADDRESS <u>Rand Md</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

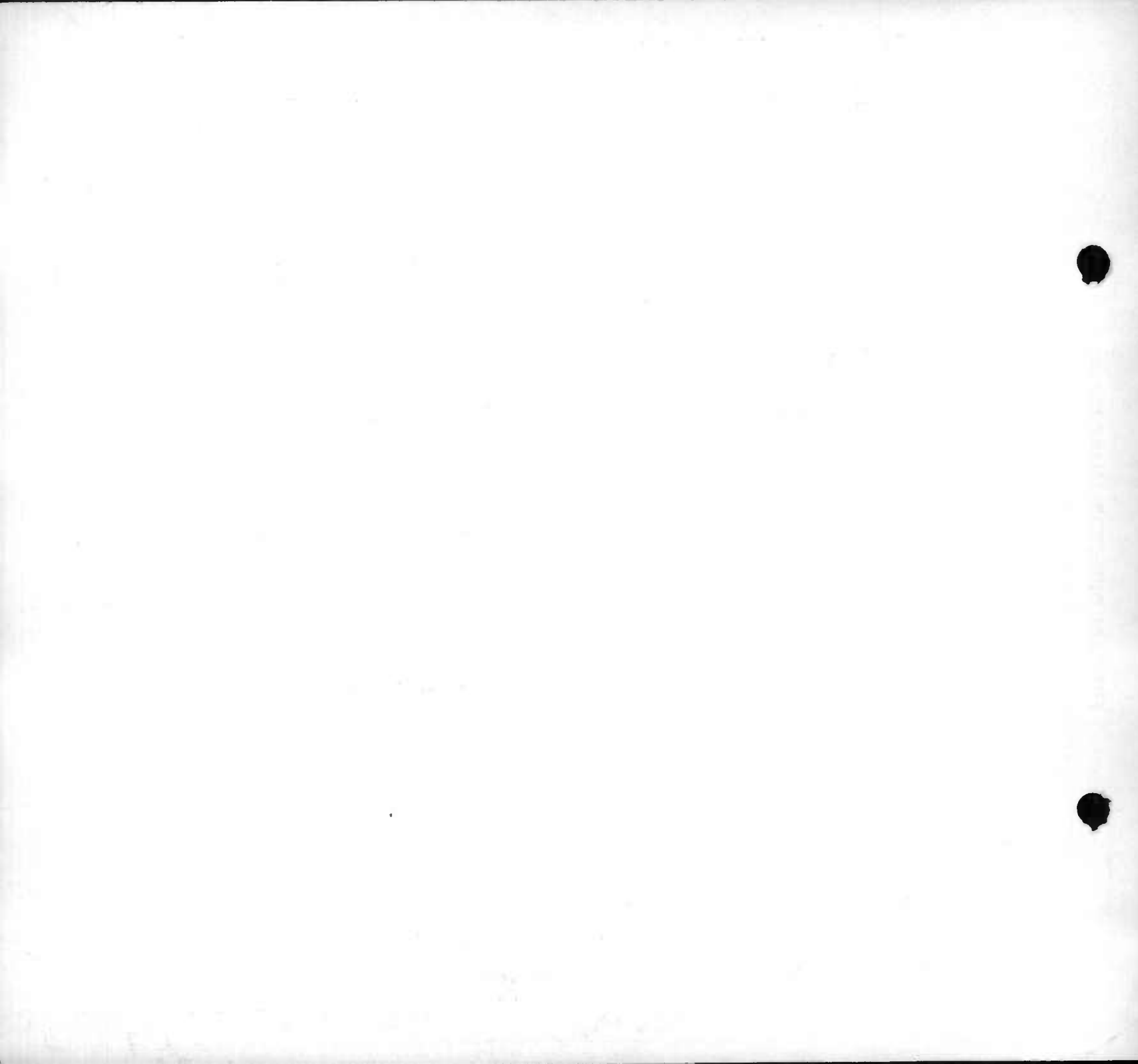
J-525 71 4073		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 4073	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Florence A. Johnson		2. DATE AND HOUR OF DEATH 4-22-71	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE Maryland B. COUNTY 2733		M.	
FULL NAME OF HOSPITAL OR INSTITUTION 00710 Linnard Street		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 2408 College Ave.		5. SEX F		6. RACE Negro	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-28 1883		9. AGE (In years last birthday) 87	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Domestic		10B. KIND OF BUSINESS OR INDUSTRY Pvt. Family		11. BIRTHPLACE (State or foreign country) Balto. Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Johnson		14. MOTHER'S MAIDEN NAME Matilda Young	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-40-6362		17. INFORMANT Delores B. Sye 710 Linnard St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral Vascular Accident		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertension		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 28 1970 to April 22 1971 , that (I) (we) last saw the deceased alive on March 22 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Fredrick K Adams		23B. DATE SIGNED 4-24-71			
23C. PHYSICIAN'S NAME (Type) F.K. ADAMS		23D. ADDRESS 1222 N. Charles St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-26-71		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. APR 27 1971		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR I.L. Brown & Son 108 W. Montgomery	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-525 71 4074		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 4074	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) DELLA JENKINS		2. DATE AND HOUR OF DEATH 4/22/71	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY Balto		M.	
FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL HOSP		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F 6. RACE N 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> UNK DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH UNK 9. AGE (in years last birthday) 80		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNK 10B. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) UNK		12. CITIZEN OF WHAT COUNTRY? UNK		13. FATHER'S NAME UNK	
14. MOTHER'S MAIDEN NAME UNIS		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-38-0551	
17. INFORMANT Wm. E. STEWART ADDRESS Nephew		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cachexia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARCINOMA OF BREAST (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 YRS YRS			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4.22 19 71 to 4.22 19 71		that (I) (we) last saw the deceased alive on 4.22 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE David P. Green DEGREE		23B. DATE SIGNED 4.22.71		23C. PHYSICIAN'S NAME (Type) DAVID P. GREEN DEGREE	
23D. ADDRESS MARYLAND GEN Hosp		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/27/71	
24C. NAME of CEMETERY or CREMATORY MT Calvary Cemetery		24D. LOCATION (City, town, or county) A A County Md		(State)	
25A. DATE REC'D BY HEALTH DEPT. APR 27 1971		25B. NAME OF REGISTRAR John E. Bailey		25C. FUNERAL DIRECTOR Adolphus Halstead ADDRESS 1206 W North Ave	



FUNERAL DIRECTOR: IMPORTANT

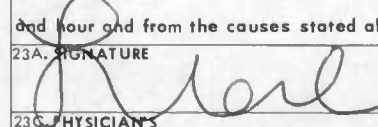
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

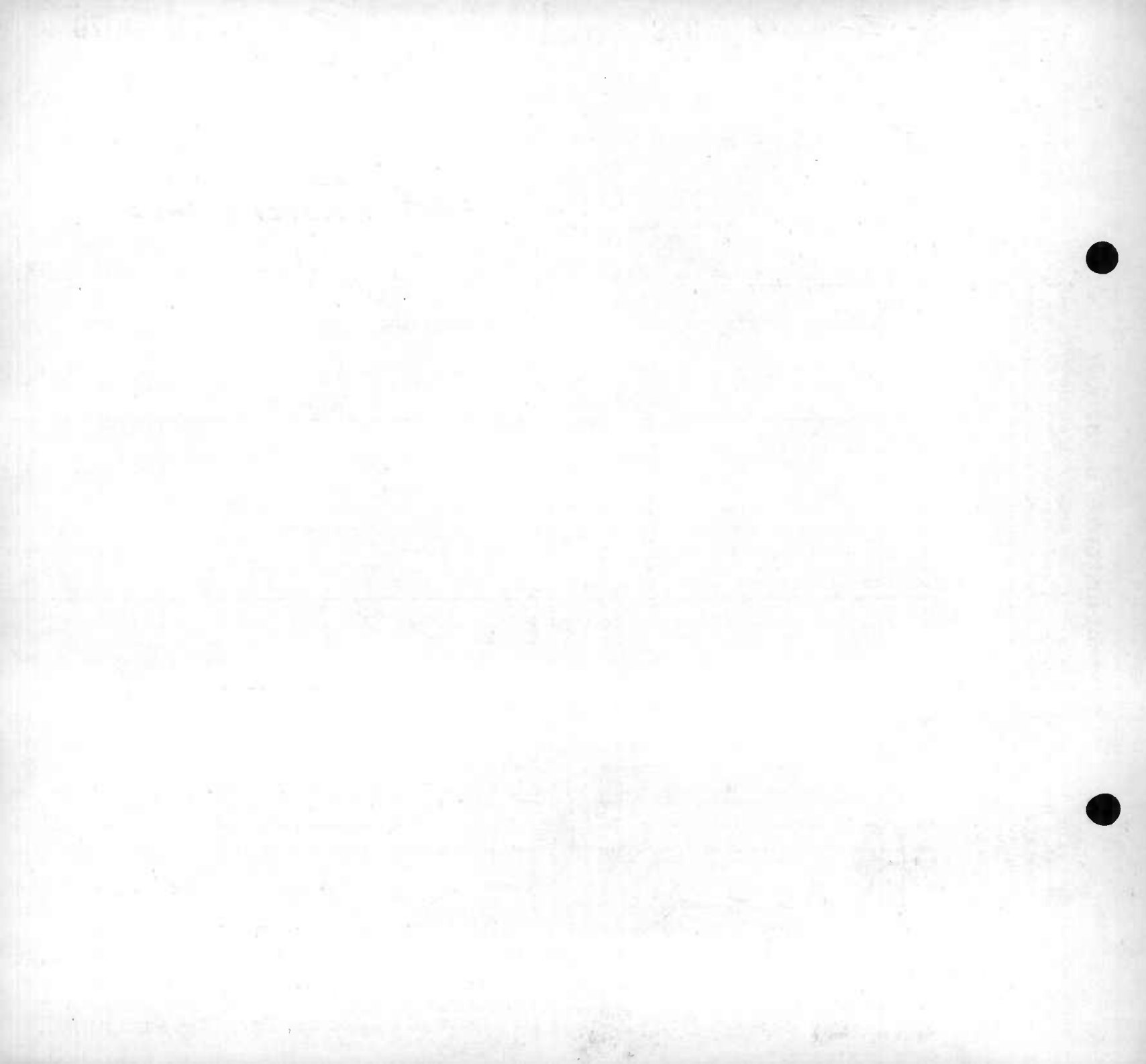
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4075	
BIRTH NO. D-006 71 4075		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Doye (Catherine) Cassie			2. DATE AND HOUR OF DEATH 4-20-71 1 45 a.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University of Maryland 38			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2732 Edmonson Av		
5. SEX f	6. RACE negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-13-27	9. AGE (In years last birthday) 43	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife			10B. KIND OF BUSINESS OR INDUSTRY NC		11. BIRTHPLACE (State or foreign country) NC
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME James Ragun		
14. MOTHER'S MAIDEN NAME Lessie?			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service unknown		
16. SOCIAL SECURITY NO. unknown			17. INFORMANT chart of Univ. Hospital ADDRESS		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II				(A) IMMEDIATE CAUSE Respiratory failure DUE TO, OR AS A CONSEQUENCE OF: (B) cerebral infarction DUE TO, OR AS A CONSEQUENCE OF: (C) Hypertension	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 4-18 / 4-19		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED diagnostic		20A. AUTOPSY? (Yes or No) yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) no			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-18-71 19 to 4-20 19 that (I) (we) last saw the deceased alive on 4-20-71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED 4-20-71	
23C. PHYSICIAN'S NAME (Type) REICHL Wolfram M.D.				23D. ADDRESS Univ. Maryland Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/26/71		24C. NAME of CEMETERY or CREMATORY Gettysburg National	
24D. LOCATION (City, town, or county) (State) Gettysburg Penn		25A. DATE REC'D BY HEALTH DEPT. APR 27 1971 25B. NAME OF REGISTRAR Adolphus Halstead			
25C. FUNERAL DIRECTOR Adolphus Halstead				ADDRESS 1206 W 4th Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

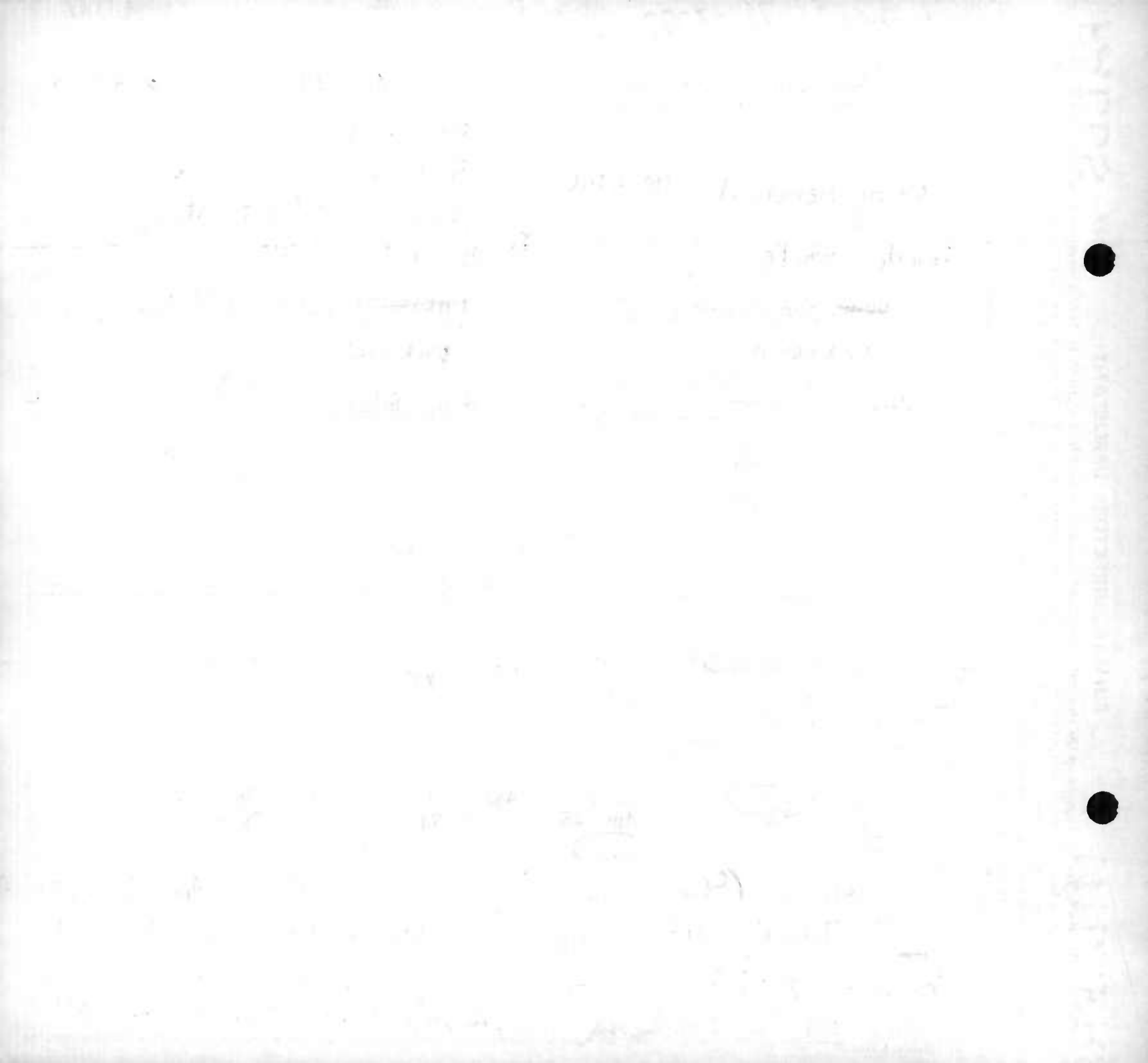
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4076	
<div style="display: flex; justify-content: space-between;"> S-536 71 4076 </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Leonard Sanders		April 24, 1971 5:00 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 90			A. STATE Maryland		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Mt. Sinai Nursing Home			B. COUNTY		2716
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3507 WOODLAND AVE		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
Male	Negro	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	6-15-00	70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Laborer				South Carolina	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
?		?		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		163-14-4323		Mrs. Lillie Cox 3507 Woodland Ave. Apt. 1-D	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
			Cancer of the lung		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Diabetes			1 year		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/15 to 4/24 1971, that (I) (we) last saw the deceased alive on 4/15 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED 4/26/71	
23C. PHYSICIAN'S NAME (Type) George Vash, M.D.				23D. ADDRESS 206 S. Gilmore St, Baltimore, Md. 21223	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
burial		4-27-71		Mt. Auburn	
24D. LOCATION (City, town, or county)		24E. ADDRESS (State)			
Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 27 1971		J. E. Jones, Jr.		21213 Marshall W. Jones, Jr., 1735 Harford Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 71 4027				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 4027	
1. NAME OF DECEASED (Type or Print) Glasgow, Grace				2. DATE AND HOUR OF DEATH Apr. 25, 1971 12:45 p.m.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Maryland B. COUNTY 1202					
FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER 3201 N. Calvert St.					
5. SEX Female	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 02-14-83	9. AGE (in years last birthday) 88	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None BACTERIOLOGIST				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) UNKNOWN ILLINOIS		12. CITIZEN OF WHAT COUNTRY? American	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 213-48-3980		17. INFORMANT Bula Glasgow		ADDRESS 14456 Geneva, New York	
18. 735.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE RESPIRATORY ARREST ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CHRONIC OBSTRUCTIVE LUNG DISEASE SEVERE KYPHOSCOLIOSIS				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:					
19. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>Apr. 21</u> 19 <u>71</u> to <u>Apr. 25</u> 19 <u>71</u> that (I) <u>(we)</u> last saw the deceased alive on <u>Apr. 25</u> 19 <u>71</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> <u>(did not)</u> view the body after death.									
23A. SIGNATURE John Ohe MD				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED Apr. 25, 1971			
23C. PHYSICIAN'S NAME (Type) John OHE MD				23D. ADDRESS Union Memorial Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION		24B. DATE 4/27/71		24C. NAME OF CEMETERY OR CREMATORY CEDAR HILL		24D. LOCATION (City, town, or county) (State) SUITLAND, Md.			
25A. DATE REC'D BY HEALTH DEPT. APR 27 1971				25B. NAME OF REGISTRAR Rose E. Kelly		25C. FUNERAL DIRECTOR W. Robert Kelly, Baltimore, Md.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

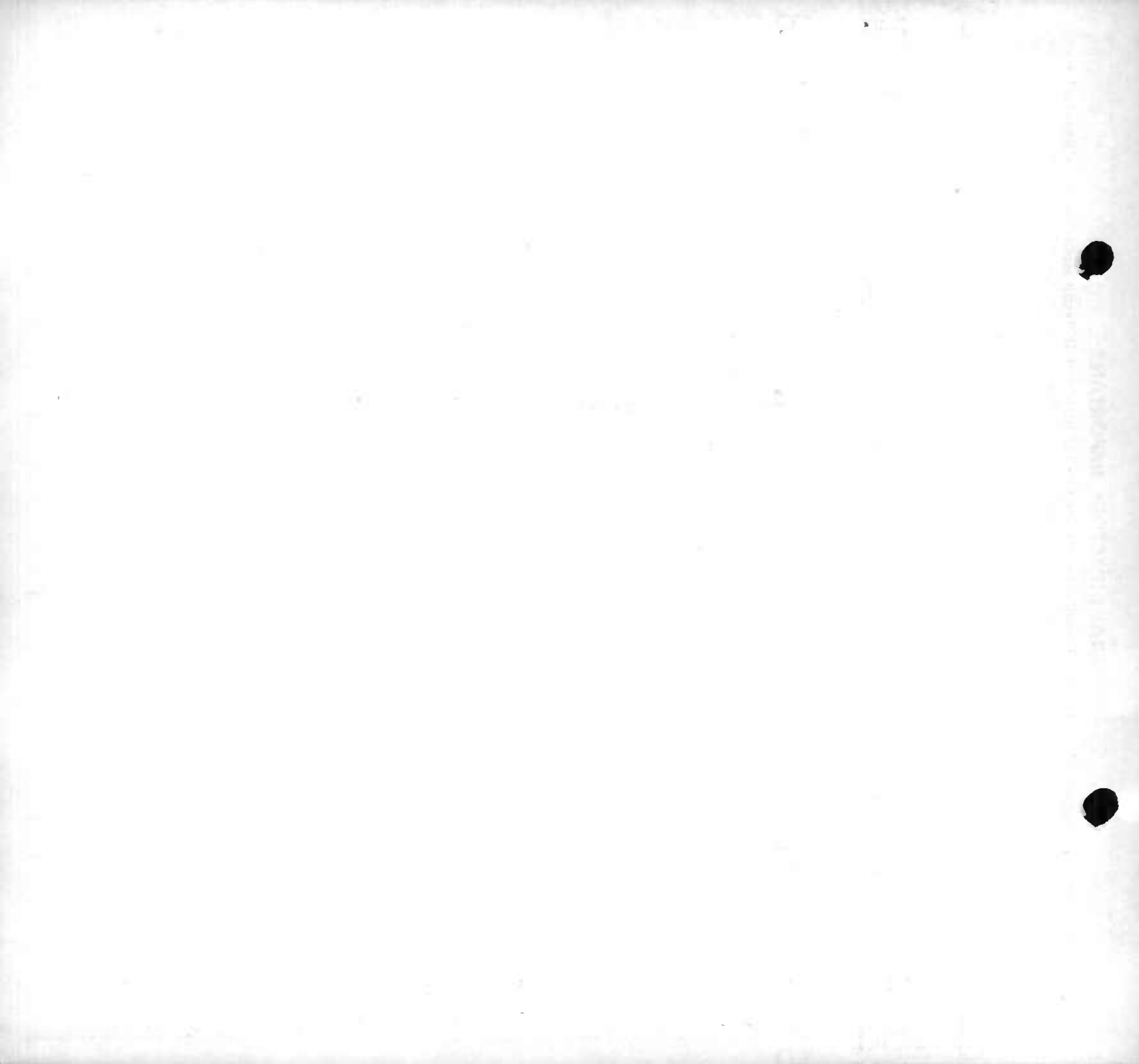
T-641		71 4078		BALTIMORE CITY HEALTH DEPARTMENT		71 4078	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) Treulieb, Alma VIOLA				2. DATE AND HOUR OF DEATH 4/22/71 2:30 p.m. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Godd Samaritan Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY 2634			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Good Samaritan Hospital 5601 Loch Raven Blvd. Balto., Md. 21239				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1137 Horner Lane							
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 06/13/12	9. AGE (In years last birthday) 58	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) button hole maker		10B. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) Balto., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Treulieb				14. MOTHER'S MAIDEN NAME Eleanor Uhlfelder (ELLANORA) UHLFELDER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215 03 6254		17. INFORMANT ADDRESS Blanche Redtman 4913 Wilshire Ave.			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Respiratory Arrest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic respin. insufficiency 2 years (B) DUE TO, OR AS A CONSEQUENCE OF: chronic Bronchitis 20 years (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (nailly medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 1970 to present 1971 that (we) last saw the deceased alive on 4/13 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Peter C. Luchsinger				23B. DATE/SIGNED 4/22/71		23C. PHYSICIAN'S NAME (Type) PETER C. LUCHSINGER MD	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-26-71		24C. NAME of CEMETERY or CREMATORY BALTIMORE CEMETERY		24D. LOCATION (City, town, or county) (State) BALTO., MD.	
25A. DATE REC'D BY HEALTH DEPT. APR 27 1971		25B. NAME OF REGISTRAR John J. Valley, M.D.		25C. FUNERAL DIRECTOR Gentry Miller - 2334 Jefferson St.		ADDRESS	

OM, OTAC

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

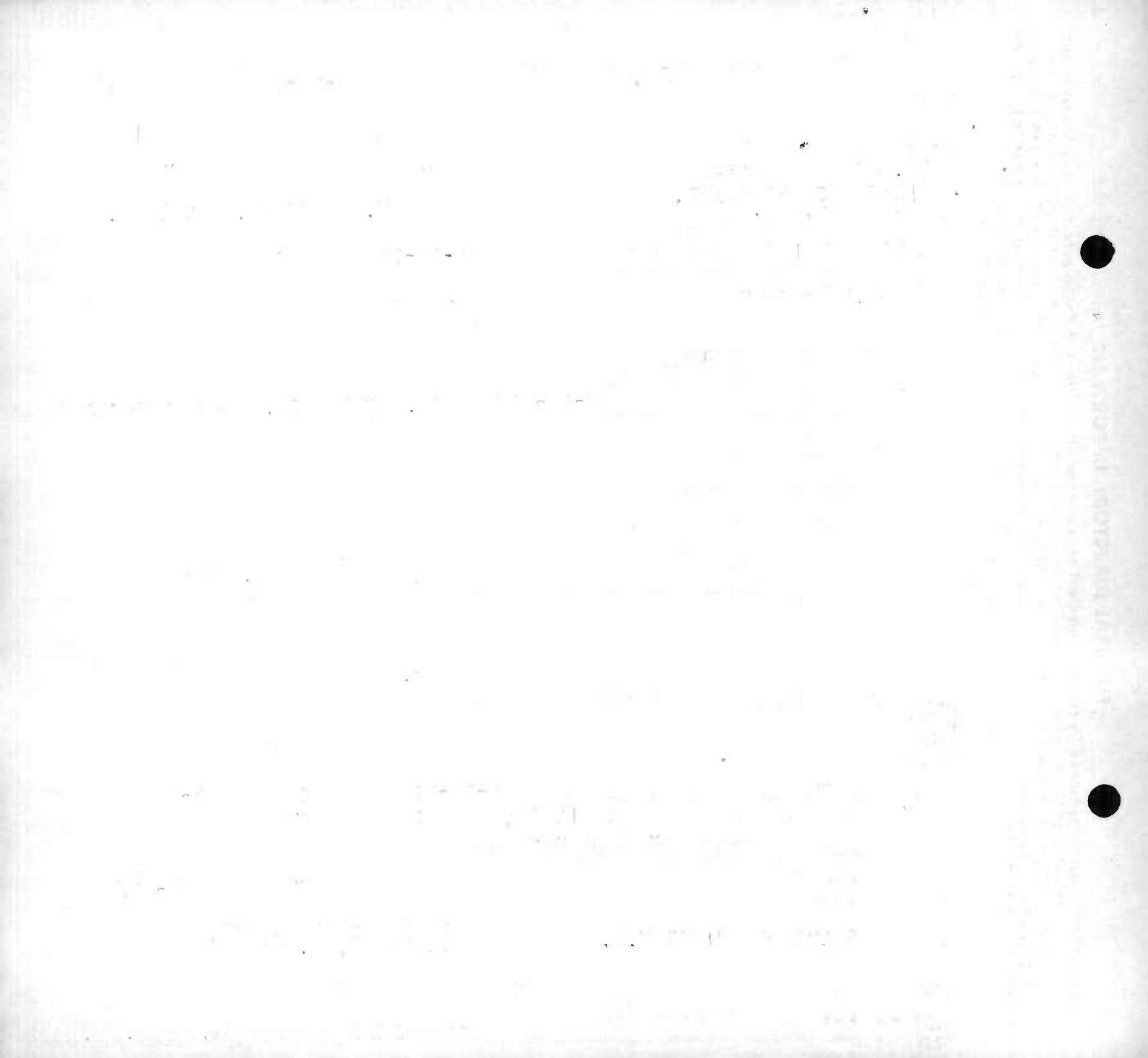
BIRTH NO. 71 4078				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 4078			
1. NAME OF DECEASED (Type or Print) Reinhardt, Richard D.				2. DATE AND HOUR OF DEATH 4/22/71 9:10 a.m.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hosp. IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 116 Oakdale Ave.							
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 03-18-24		9. AGE (In years last birthday) 47		10. Under 1 Yr. Months: Days: Hours: Min.		11. Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Analyst				10B. KIND OF BUSINESS OR INDUSTRY USF & G		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Frank C. Reinhardt				14. MOTHER'S MAIDEN NAME Helen K							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service Unknown WW 2				16. SOCIAL SECURITY NO. 212-206679		17. INFORMANT Mrs. Helen R. Reinhardt, 116 Oakdale Ave.				ADDRESS	
18. 3-71-01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hepatic Failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Possible alcoholic Hepatitis Acute and Chronic peptic esophagitis				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hepatic Failure (B) Possible alcoholic Hepatitis DUE TO, OR AS A CONSEQUENCE OF: Acute and Chronic peptic esophagitis (C) Acute and Chronic peptic esophagitis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/6 19 71 to 4/22 19 71 that (I) (we) last saw the deceased alive on 4/22 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE H. Earl Cotman				23B. DATE SIGNED 4/22/71				23C. PHYSICIAN'S NAME (Type) H. Earl Cotman, M.D.			
23D. ADDRESS Union Memorial Hospital				23E. FUNERAL DIRECTOR Witzke, 1630 Edmondson Ave., 21228				23F. NAME OF REGISTRAR			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 4/29/71				24C. NAME OF CEMETERY OR CREMATORY Gettysburg Nat'l Cemetery			
24D. LOCATION Gettysburg, Pennsylvania				24E. DATE REC'D BY HEALTH DEPT. APR 27 1971				24F. NAME OF REGISTRAR John E. Hickey			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4080	
<div style="display: flex; justify-content: space-between;"> (15-425) 71 4080 BIRTH NO. </div>					
1. NAME OF DECEASED (Type or Print) SKALCHUNES, JOHN PETER			2. DATE AND HOUR OF DEATH 4-23-71 7:45 A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <div style="display: flex; justify-content: space-between;"> <div> FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL WILKENS & CATON AVE BALTIMORE, MD. 21228 </div> <div> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) </div> </div>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) <div style="display: flex; justify-content: space-between;"> <div> A. STATE MARYLAND </div> <div> B. COUNTY CITY 1803 </div> </div>		
5. SEX MALE			6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 03-15-15		9. AGE (in years last birthday) 56		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HORSEMAN & COOK	
11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John Peter Skalchunes			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW2		16. SOCIAL SECURITY NO. 9382? 280-18-9380		17. (INFORMANT ADDRESS) ST. AGNES REC. ROOM WILKENS & CATON	
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div> (A) IMMEDIATE CAUSE Bilateral Pneumonia DUE TO, OR AS A CONSEQUENCE OF: (B) Non-Traumatic Subarachnoid Hemorrhage (C) Acute Fatty Liver </div> <div> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH </div> </div>					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 04-19-71 to 04-23-71 that (X) (we) last saw the deceased alive on APRIL 19, 19 71 and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED 04-23/71	
23C. PHYSICIAN'S NAME (Type) SALVADOR QUIROZ M.D.				23D. ADDRESS WILKENS & CATON AVE. BALTIMORE MD 21228	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/29/71		24C. NAME of CEMETERY or CREMATORY Gettysburg Nat'l Cemetery	
24D. LOCATION (City, town, or county) (State) Gettysburg, Maryland		25A. DATE REC'D BY HEALTH DEPT. APR 27 1971			
25B. NAME OF REGISTRAR John E. Taylor, Jr.		25C. FUNERAL DIRECTOR ADDRESS Witzke, 101 Edmondson Av., Balto., Md. 21229			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 4081
CERTIFICATE OF DEATH				REG. NO. _____
BIRTH NO. <u>45-166</u>		71 4081		
1. NAME OF DECEASED (Type or Print) <u>Spurrier, Mr. Harvey E. Sr.</u>		2. DATE AND HOUR OF DEATH <u>4/24/71</u> <u>8:00</u> <u>8</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>34 Bon Secours Hospital</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <u>Male</u> 6. RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		8. DATE OF BIRTH <u>2/24/98</u> 9. AGE (In years last birthday) <u>73</u>		
10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Spurrier, John H.</u>		14. MOTHER'S MAIDEN NAME <u>Laura Beall</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-05-7981A</u>		
		17. INFORMANT <u>Mrs. Harvey E. Spurrier, Sr., 4901 Parkton Ct.</u>		
18. <u>492X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Congestive bronchopneumonia</u> 1. This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause 1A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>years</u>		
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? <input type="checkbox"/> In Baltimore City, give exact location
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (we) (this hospital) attended the deceased from <u>4-24</u> 19 <u>71</u> to <u>4-24</u> 19 <u>71</u> that (we) last saw the deceased alive on <u>4-24</u> 19 <u>71</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>L. L. DeBorja M.D.</u>		23B. DATE SIGNED <u>4-24-71</u>		
23C. PHYSICIAN'S NAME (Type) <u>L. L. DeBorja M.D.</u>		23D. ADDRESS <u>Bon Secours Hosp. Balto. Md. 21223</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/27/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>
24D. LOCATION <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 27 1971</u>		
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Witzke, 1630 Edmondson Av., Catonsville, Md.</u>		



W 300

71 4082

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 4082

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

FRED WHITE

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

April 21, 1971

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Bon Secours Hospital (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

April 21, 1971

11:55 A.M.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

Maryland

B. COUNTY

1901

6. SEX

Male

7. RACE

Negro

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

4-30-32

10. AGE (In years
lost birthday)

38

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1525 W. Fairmount Avenue

11. BIRTHPLACE (State or foreign country)

LANCASTER, S.C.

12. CITIZEN OF

U.S.A.

13. FATHER'S NAME

JAMES WHITE

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

ETHEL BRICE

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or doles of service)

YES

WW II

17. SOCIAL
SECURITY NO.

244-36-3256

18. INFORMANT

ADDRESS

ETHEL WHITE- 1029 W. Fayette Street

19.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Lobar pneumonia complicating fatty liver

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (if in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

m.

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

April 22, 1971

24A. BURIAL CREMATION,
REMOVAL (Specify)
BURIAL

24B. DATE

4-26-71

24C. NAME OF CEMETERY or CREMATORY

BALTIMORE NATIONAL CEMTERY

24D. LOCATION (City, town, or county)

BALTIMORE, MARYLAND

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 21 1971

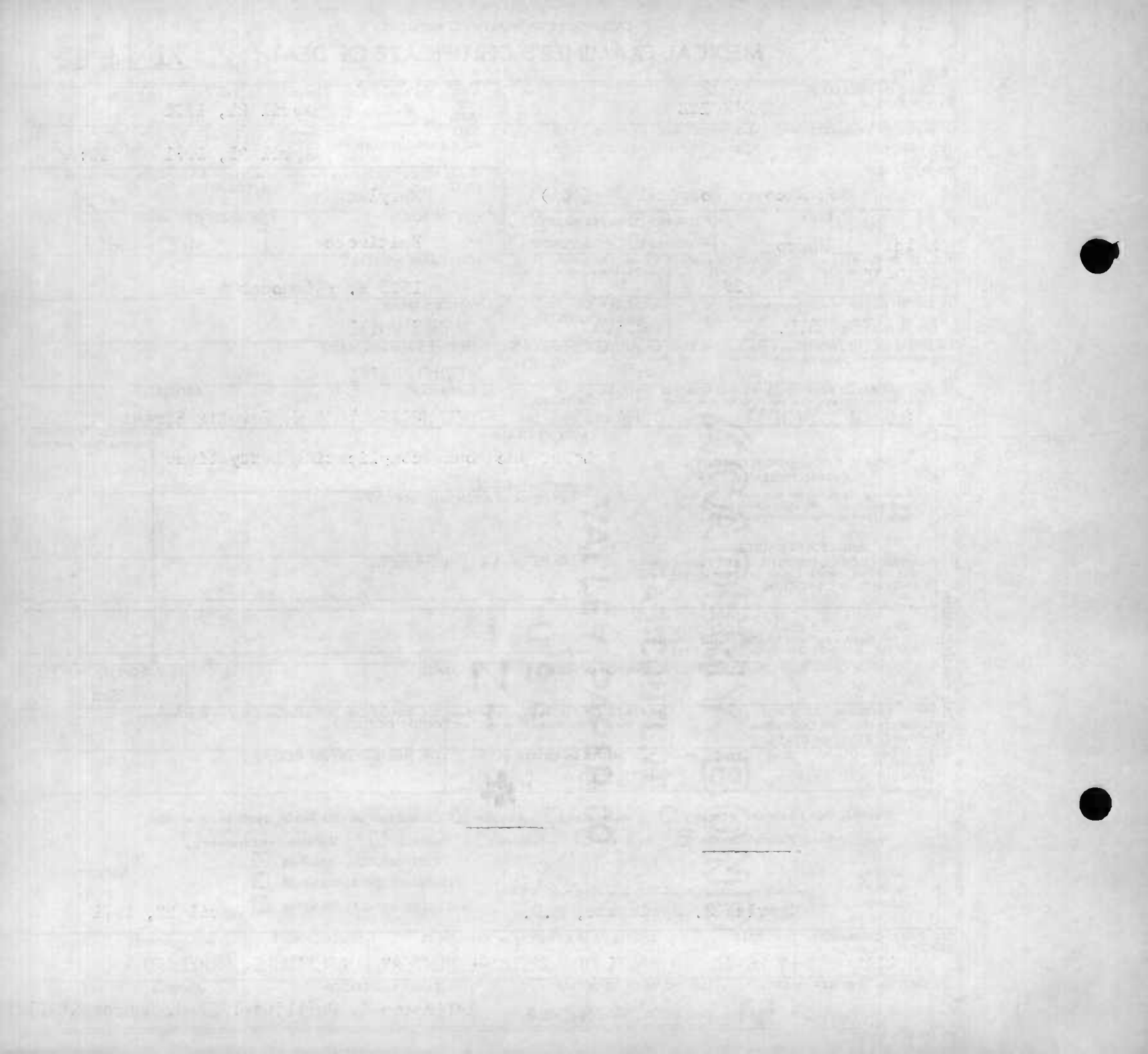
25B. NAME OF REGISTRAR

W. E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Arlington S. Phillips-1727 N. Monroe St-21217

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

71 4083

REG. NO. 71 4083

BIRTH NO.

1. NAME OF DECEASED (Type or Print) **EDGAR S. SHELTON**

2. DATE AND HOUR OF DEATH **APRIL 24, 1971 12¹⁰ A.M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE **MD.** B. COUNTY **17-02**

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) **MARYLAND GENERAL HOSPITAL**

C. CITY OR TOWN **BALTIMORE** D. INSIDE CITY LIMITS? YES ☒ NO ☐

E. STREET AND NUMBER **1400 JOHN ST.**

5. SEX **MALE** 6. RACE **NEGRO** 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH **12-25-04** 9. AGE (in years last birthday) **66** If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **RETIRED** 10B. KIND OF BUSINESS OR INDUSTRY **CHAUFFER** 11. BIRTHPLACE (State or foreign country) **PHILADELPHIA, PA** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **MOTEN SHELTON** 14. MOTHER'S MAIDEN NAME **CHARLOTTE MYERS**

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) **YES W W T T** 16. SOCIAL SECURITY NO. **217-07-1559** 17. INFORMANT **Mrs. Marie Dameron** ADDRESS **4212 Evans Chapel Rd.**

18. **1855 X I** CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE **CARCINOMA OF PROSTATE** YEARS

DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). **ATHEROSCLEROTIC CARDIOVASCULAR DISEASE** YEARS

19A. DATE OF OPERATION **0** 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED **0** 20A. AUTOPSY? (Yes or No) **0** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? **0**

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED While At ☐ Not While At ☐ Work ☐ At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~(I)~~ **(he)** ~~(this hospital)~~ attended the deceased from **APRIL 23 1971** to **APRIL 24 1971** that ~~(I)~~ **(we)** last saw the deceased alive on **APRIL 23 1971** and that ~~(my)~~ **(our)** opinion death occurred on the date and hour and from the causes stated above. ~~(I)~~ **(We)** ~~(did)~~ **(did not)** view the body after death.

23A. SIGNATURE **William D. Hakkarinen MD** 23B. DATE SIGNED **APRIL 24, 1971**

23C. PHYSICIAN'S NAME (Type) **WILLIAM D. HAKKARINEN MD** 23D. ADDRESS **MD. GEN. HOSP., BALTIMORE, MD**

24A. BURIAL CREMATION, REMOVAL (Specify) **REMOVAL** 24B. DATE **4-26-71** 24C. NAME OF CEMETERY OR CREMATORY **FAIRVIEW, VIRGINIA** 24D. LOCATION (City, town, or county) (State) **HARPERS FERRY, WEST VIRGINIA**

25A. DATE REC'D BY HEALTH DEPT. **APR 27 1971** 25B. NAME OF REGISTRAR **Robert E. Farley, R.D.** 25C. FUNERAL DIRECTOR **Arlington S. Phillips** ADDRESS **1727 N. Monroe St-21217**

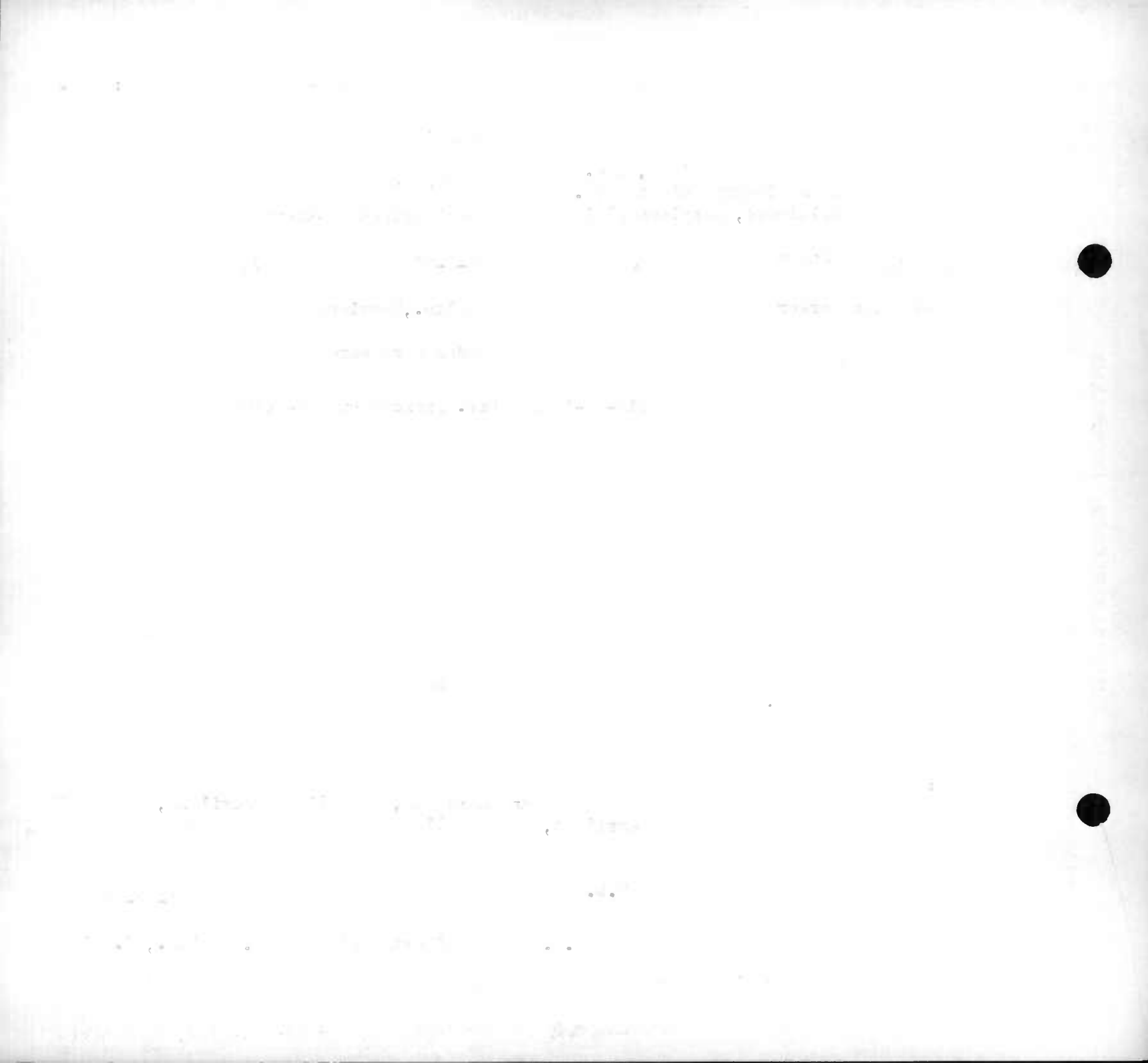
VS 150-REV. 1/1/68

Addressed to Mr. J. B. Smith
12 = 21 11 11 11 11

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 4084</u>	
BIRTH NO. <u>71 4084</u>					
1. NAME OF DECEASED (Type or Print) <u>EDNA MARY LOKEMAN</u>		2. DATE AND HOUR OF DEATH <u>4-23-71</u> <u>4:30 a.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Provident Hospital, Inc.</u> <u>2600 Liberty Heights Ave.</u> <u>Baltimore, Maryland 21215</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1607</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3052 Brighton Street</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-8-95</u>	9. AGE (In years last birthday) <u>76</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic Worker</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto., Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>CHARLES WARD</u>		14. MOTHER'S MAIDEN NAME <u>Edna Mary Ward</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-26-1289</u>		17. INFORMANT <u>Mrs. Frances Hughes- daughter</u> ADDRESS <u>SAME</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Cerebral Vascular Disease</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Arteriosclerosis, HCUV, several years</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebral Vascular Disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>March 23, 1971</u> to <u>April 23, 1971</u> that (I) (we) last saw the deceased alive on <u>April 23, 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>M. J. Shafi</u> M.D. DEGREE		23B. DATE SIGNED <u>4-23-71</u>		23C. PHYSICIAN'S NAME (Type) <u>SHAFI JAVAD</u> M.D. DEGREE	
23D. ADDRESS <u>2600 Liberty Heights Ave. Balto., Md. 21215</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
24B. DATE <u>4-26-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>ARBUTUS MEMORIAL PARK</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 26 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Arlington S. Phillips-1727 N. Monroe st-21217</u> ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 4085</u>	
BIRTH NO. <u>71 4085</u>		1. NAME OF DECEASED (Type or Print) <u>ILIA POPICHTZ</u>		2. DATE AND HOUR OF DEATH <u>4.24.71</u> <u>7.30 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>35 Church Home & Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>238 S. EDEN STREET 21231</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7.20.1890</u>	9. AGE (In years last birthday) <u>80 yrs</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed LABOR</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>BETH STEEL CO</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>RUSSIAN</u>		13. FATHER'S NAME <u>TYR ANNY POPICHTZ</u>			
14. MOTHER'S MAIDEN NAME <u>POWASA</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u>			
16. SOCIAL SECURITY NO. <u>913-07-7836</u>		17. INFORMANT <u>HELEN CASCIO 6604 Hartwist St.</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>gangrene left foot & diabetes & chronic heart disease & pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>& Possible M.I.</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>4.22.71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>gangrene left foot</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> NO			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>3.15.1971</u> to <u>4.24.1971</u> that (I) (we) last saw the deceased alive on <u>4.24.1971</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Vasant Datta M.D.</u>		23B. DATE SIGNED <u>4.24.71</u>		23C. PHYSICIAN'S NAME (Type) <u>VASANT DATTA M.D.</u>	
23D. ADDRESS <u>Church Home & Hospital Baltimore MD</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
24B. DATE <u>APR 28 1971</u>		24C. NAME OF CEMETERY OR CREMATORY <u>ST ANDREW'S CEMETERY</u>		24D. LOCATION (City, town, or county) (State) <u>GERMAN HILL RD BALTO MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 27 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>DIPPEL BROS 1800 E LOMBARD ST</u>	

Declaration of Intention for Ilia Popichitz dated June 8, 1936 at
Baltimore, Md. showing that he was born in
Russia on July 20, 1890 and affidavit of Mrs.
Josephine Androsik 5-5-71 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 71 4086				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH X		REG. NO. 71 4086	
1. NAME OF DECEASED (Type or Print) <u>MARY E. Loeffler</u>				2. DATE AND HOUR OF DEATH <u>4-27-71</u> <u>1:20 P.M.</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Fred.</u>					
FULL NAME OF HOSPITAL OR INSTITUTION <u>46 Lutheran</u>				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>FREDRICK</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>F</u>		6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-12-09</u>		9. AGE (in years last birthday) <u>62</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JAMES MACKLE</u>				14. MOTHER'S MAIDEN NAME <u>JOSEPHINE KANE</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>157-22-3735</u>		17. INFORMANT		ADDRESS	
18. <u>3 217 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Liver Cirrhosis</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Ascites & Esophageal</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Varices</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>few yrs.</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If only medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>4-23</u> 19 <u>71</u> to <u>4-27</u> 19 <u>71</u> that (I) (we) lost saw the deceased alive on <u>4-27</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Okja Kim</u> M.D.				23B. DATE SIGNED <u>4-27-71</u>		23C. PHYSICIAN'S NAME (Type) <u>OK JA KIM M.D.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-30-71</u>		24C. NAME of CEMETERY or CREMATORY <u>St. Mary's Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>East Orange, N.J.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 27 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, MD</u>		25C. FUNERAL DIRECTOR <u>Mr. John Broome</u>		ADDRESS <u>Caldwell, N.J.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
71 4087					REG. NO. 71 4087						
BIRTH NO. 1. NAME OF DECEASED (Type or Print) James W. Harrison					2. DATE AND HOUR OF DEATH April 24, 1971 8:50 P.M.						
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2640 Dulany Street					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 205 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2640 Dulany Street 21223						
5. SEX M		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 22, 1877		9. AGE (In years lost birthday) 93 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter					10B. KIND OF BUSINESS OR INDUSTRY Self-employed		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Joseph S. Harrison					14. MOTHER'S MAIDEN NAME ----- Tarbutton						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 216-10-1555		17. INFORMANT ADDRESS Mabel M. Lapole 501 So. Caton Ave. 21229				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerotic CV Disease</i> (B) <i>Hypertension</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>old age</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>40 yrs</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (not hospital) attended the deceased from <i>Sept 17 1969</i> to <i>April 17 1971</i> , that (I) (we) lost saw the deceased alive on <i>17 April 1971</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>H. H. Baylus</i>					23B. DATE SIGNED <i>26 April 71</i>			23C. PHYSICIAN'S NAME (Type) H. H. BAYLUS			
23D. ADDRESS 1600 WILKENS AVE					24A. BURIAL CREMATION, REMOVAL (Specify) Burial						
24B. DATE 4/28/71		24C. NAME OF CEMETERY or CREMATORY Glen Haven Mem. Park			24D. LOCATION (City, town, or county) (State) Anne Arundel Co., Maryland						
25A. DATE REC'D BY HEALTH DEPT. <i>APR 27 1971</i>					25B. NAME OF REGISTRAR <i>[Signature]</i>						
25C. FUNERAL DIRECTOR Walters Funeral Home Pratt & Stricker					ADDRESS Streets 21223						

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

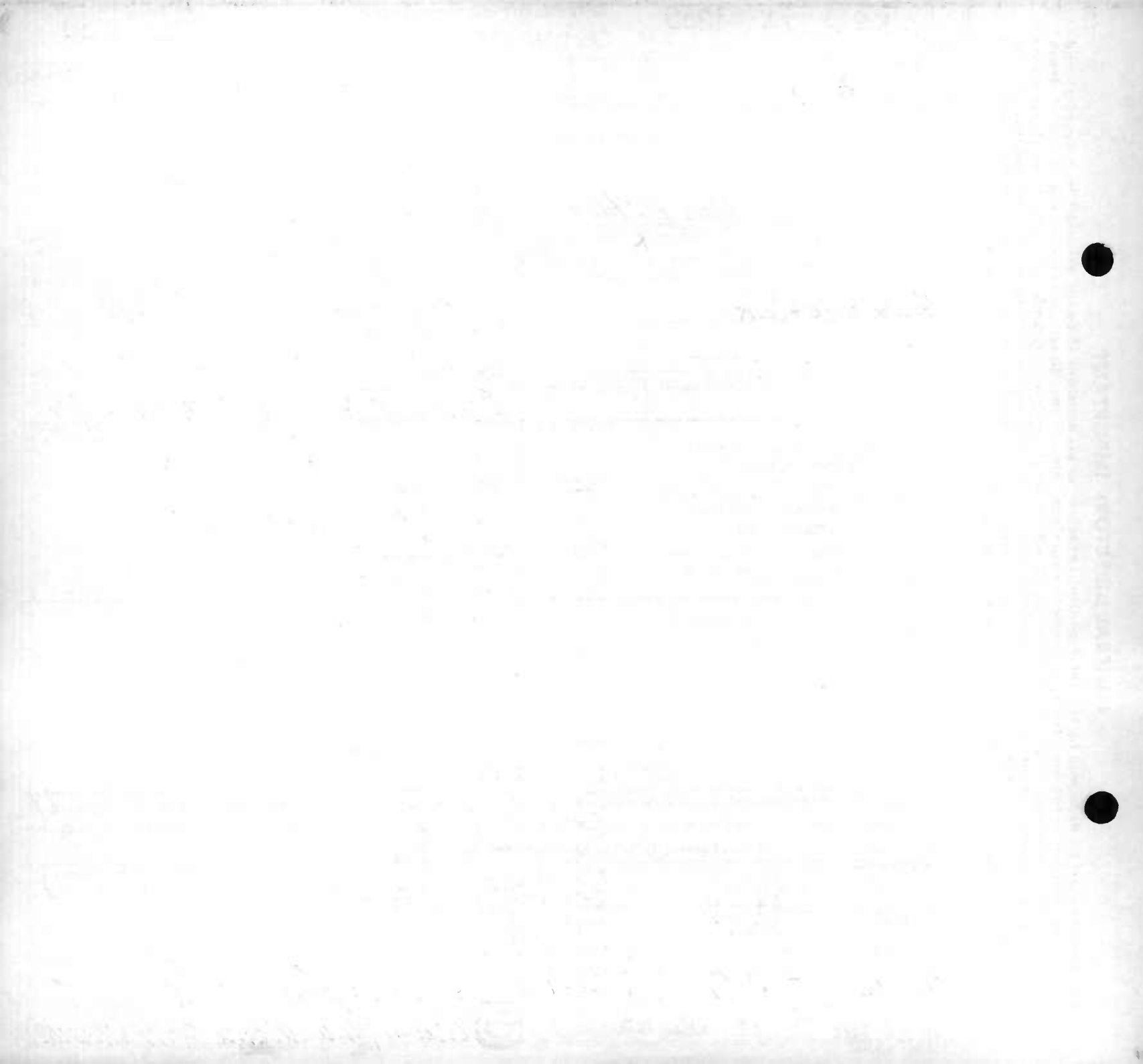
Baltimore City Health Department				REG. NO. 71 4088	
BIRTH NO. 6-520		71 4088		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) IDA BANKS			2. DATE AND HOUR OF DEATH 4/22/71 8:30 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 70 Bolton Hill Nursing Home			A. STATE MARYLAND B. COUNTY 402		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 756 W Redwood Street		
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/31/98	9. AGE (in years last birthday) 73	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			11. BIRTHPLACE (State or foreign country) A.A. Co. Md		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME John H. Bowie			14. MOTHER'S MAIDEN NAME Mary Toogood		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		
			17. INFORMANT Admission Record ADDRESS		
18. 2309 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE congestive heart failure DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			(B) Hypertensive C.V. disease DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) Diabetic retinitis		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Qualify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED		
			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 4/16 19 71 to 4/22 19 71 that (I) (we) last saw the deceased alive on 4/22 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]			23B. DATE SIGNED 4/24/71		
23C. PHYSICIAN'S NAME (Type) ALAN H. MATHIAS MD			23D. ADDRESS 2 E Paul St Baltimore Md		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 4/28/71		
24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.			24D. LOCATION (City, town, or county) (State) Balto - Md		
25A. DATE REC'D BY HEALTH DEPT. APR 27 1971			25B. NAME OF REGISTRAR John E. Fisher, M.D.		
			25C. FUNERAL DIRECTOR Williams Funeral Home ADDRESS 3199 Snowden St		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

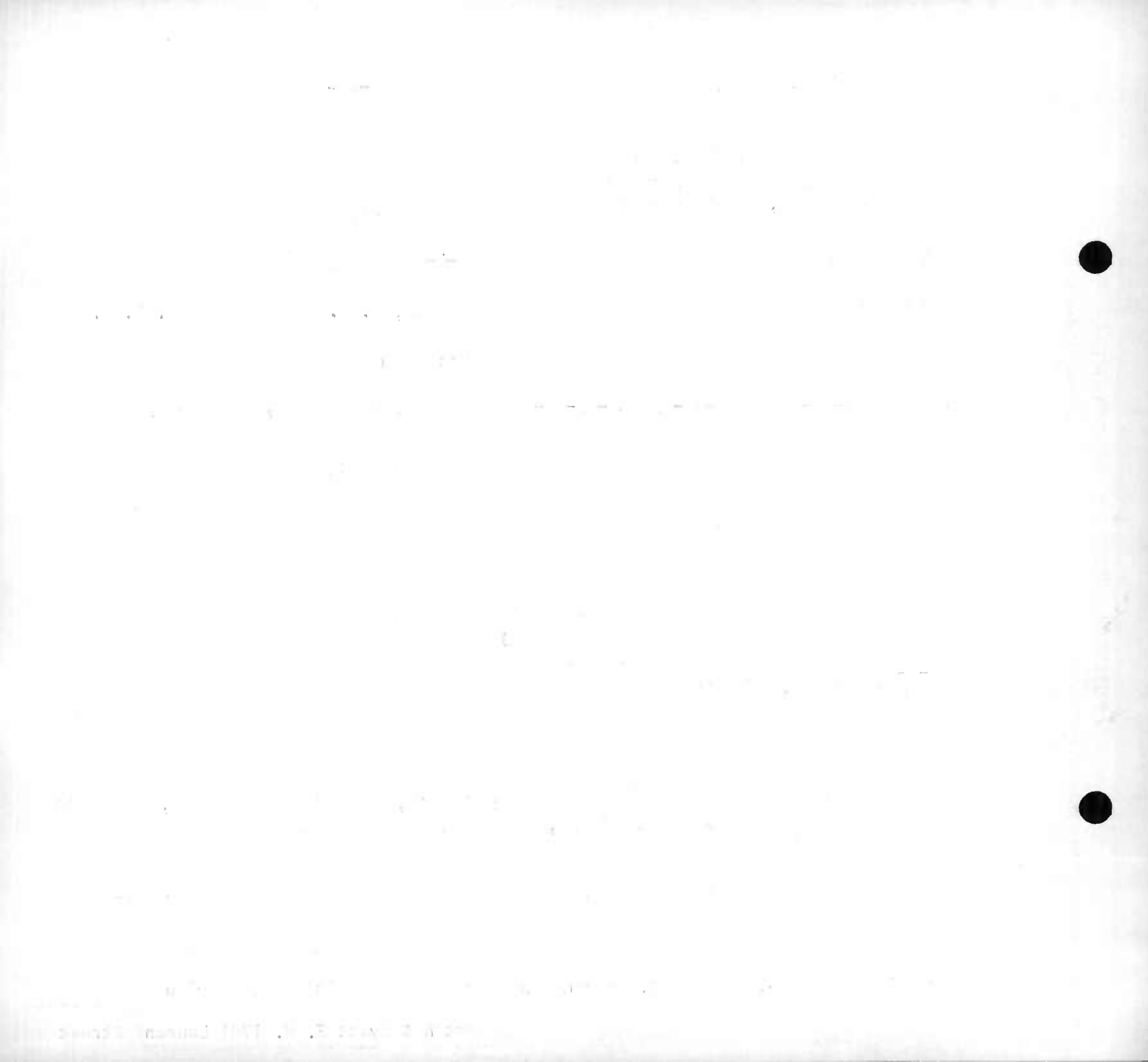
Baltimore City Health Department				REG. NO. 71 4089	
M. 320 71 4089				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Mrs. Hazel</i>		2. DATE AND HOUR OF DEATH <i>4-22-71 12 40 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <i>South Baltimore General Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <i>Md.</i>	B. COUNTY <i>25-72</i>
5. SEX <i>Fem.</i>		6. RACE <i>Negro</i>		C. CITY OR TOWN <i>Baltimore</i>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>1-31-21</i>		9. AGE (in years last birthday) <i>50</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife & Cook</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>William Ford</i>			
14. MOTHER'S MAIDEN NAME <i>Lillie Goodwyn</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Calvin Tiller 2721 Katehouse Dr.</i>			
18. <i>569.31</i>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		<i>Hypernatremia</i>			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		<i>Hyperosmolar dehydration</i>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		<i>multiple fistulae of small & large bowels</i>			
		(C) <i>abdominal abscess, septicemia.</i>			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <i>4-5-71</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Colostomy</i>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>4-1-71</i> 19 <i>71</i> to <i>4-22</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>4-22</i> 19 <i>71</i> and that (in) (my) (our) applan death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Narong Ruangruachira M.D.</i>				23B. DATE SIGNED <i>4-22-71</i>	
23C. PHYSICIAN'S NAME (Type) <i>NARONG RUANGRUACHIRA M.D.</i>				23D. ADDRESS <i>S B G H Balto Md 21230</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>4/27/71</i>		24C. NAME OF CEMETERY or CREMATORY <i>W. L. Brown Cem. Balto. Md</i>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <i>APR 27 1971</i>			
25B. NAME OF REGISTRAR <i>J. E. J. J. J.</i>		25C. FUNERAL DIRECTOR <i>William J. J. J. J.</i>			
25D. ADDRESS		25E. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 4090</u>	
8-536 71 4090		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		SANDERS, Harold MNM		4-25-71	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>23</u> Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218			A. STATE <u>Maryland</u> B. COUNTY <u>2562</u>		
			C. CITY OR TOWN <u>Cherry Hill</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>2712 Woodview Road</u>		
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-7-14</u>	9. AGE (in years last birthday) <u>56</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brick Maker</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Sumpter, S. C.</u>	
13. FATHER'S NAME <u>Hurbert Sanders</u>		14. MOTHER'S MAIDEN NAME <u>Martha Sanders</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>1-31-42 to 10-16-43 250-05-48-98</u>		17. INFORMANT ADDRESS <u>VA Hospital Records, Baltimore, Md 21218</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Diagnosed 2 1/2 months</u>		
			(A) IMMEDIATE CAUSE <u>Hodgkins disease</u> DUE TO, OR AS A CONSEQUENCE OF:		
			(B) _____ DUE TO, OR AS A CONSEQUENCE OF:		
			(C) _____ DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			<u>Subphrenic hematoma, L pleural effusion</u> <u>Staph UTI; GI Bleeding Anemia</u>		
19A. DATE OF OPERATION <u>2-27-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Hodgkins disease Hematoma</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(H)</u> (this hospital) attended the deceased from <u>December 12,</u> 19 <u>70</u> to <u>April 25,</u> 19 <u>71</u> that <u>(H)</u> (we) last saw the deceased alive on <u>April 25,</u> 19 <u>71</u> and that <u>(H)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(H)</u> (We) (did) (not) view the body after death.					
23A. SIGNATURE <u>MA Calkins MD</u>				23B. DATE SIGNED <u>4/26/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>MD</u>				23D. ADDRESS <u>3900 Loch Raven Boulevard</u> <u>Baltimore, Maryland 21218</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-29-71</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Auburn Cemetery</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 27 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD</u>		25C. FUNERAL DIRECTOR <u>Morton & Dyett F. H. 1701 Laurens Street</u>	
		24D. LOCATION <u>Baltimore, Maryland</u>		25D. ADDRESS <u>21217</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 4091</u>	
C-236 <u>71 4091</u>		CERTIFICATE OF DEATH			
BIRTH NO. <u>CHESTER LORETTA</u>		2. DATE AND HOUR OF DEATH <u>4/24/71 6:30 P.M.</u>			
1. NAME OF DECEASED (Type or Print)		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI Hospital of Baltimore</u> <u>42</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
				A. STATE <u>Maryland</u> B. COUNTY <u>2002</u>	
5. SEX <u>F</u> 6. RACE <u>N</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>19 N. GORMAN Ave. #21223</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>6/27/96</u> 9. AGE (in years last birthday) <u>74</u>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
<u>Baltimore, Md.</u>		<u>U.S.A.</u>		<u>Elisha Lucas</u>	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
<u>Maria Lucas</u>		16. SOCIAL SECURITY NO. <u>217-16-0839</u>			
17. INFORMANT		ADDRESS			
<u>Melvin Jones</u>		<u>1009 Bethune Rd.</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CVA coma and C.R. arrest</u> <u>Hypertension</u>			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>8/p: Carcinoma of @ breast.</u> <u>- Carcinoma of the bladder -</u>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE OLD INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW OLD INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/23/71</u> to <u>4/24/71</u> that (I) (we) last saw the deceased alive on <u>4/24/71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>H. Leveque</u>		23B. DATE SIGNED <u>4/24/71</u>		23C. PHYSICIAN'S NAME (Type) <u>H. LEVEQUE</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-28-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Ceme.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 27 1971</u>		25B. NAME OF REGISTRAR <u>Robert H. ...</u>		25C. FUNERAL DIRECTOR <u>Morton & Dyett F. H.</u>	
				ADDRESS <u>1701 Laurens St.</u>	



1		71 4092		BALTIMORE CITY HEALTH DEPARTMENT	
M-460		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 71 4092	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
		Willie E. Miller			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 24 71 1:10 p.m.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Maryland 2102	
00 833 W. Ostend St.					
6. SEX male		7. RACE colored		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 5/15/24		10. AGE (In years last birthday) 46		11. BIRTHPLACE (State, or foreign country) North Carolina	
		12. CITIZEN OF U.S.A.		13. FATHER'S NAME	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT E. Walker 16 N. Barfield St. S.C. 29403	
				ADDRESS Manning	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23.					
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Werner U. Spitz, M.D. Deputy Chief Medical Examiner		DATE SIGNED 4/24/71	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4/28/71		24C. NAME OF CEMETERY or CREMATORY Manning Cemetery	
Burial				24D. LOCATION (City, town, or county) (State) Manning, S.C.	
25A. DATE REC'D BY HEALTH DEPT. APR 27 1971		25B. NAME OF REGISTRAR Charles A. Rice		25C. FUNERAL DIRECTOR Charles A. Rice 661 W. Barre ST.	

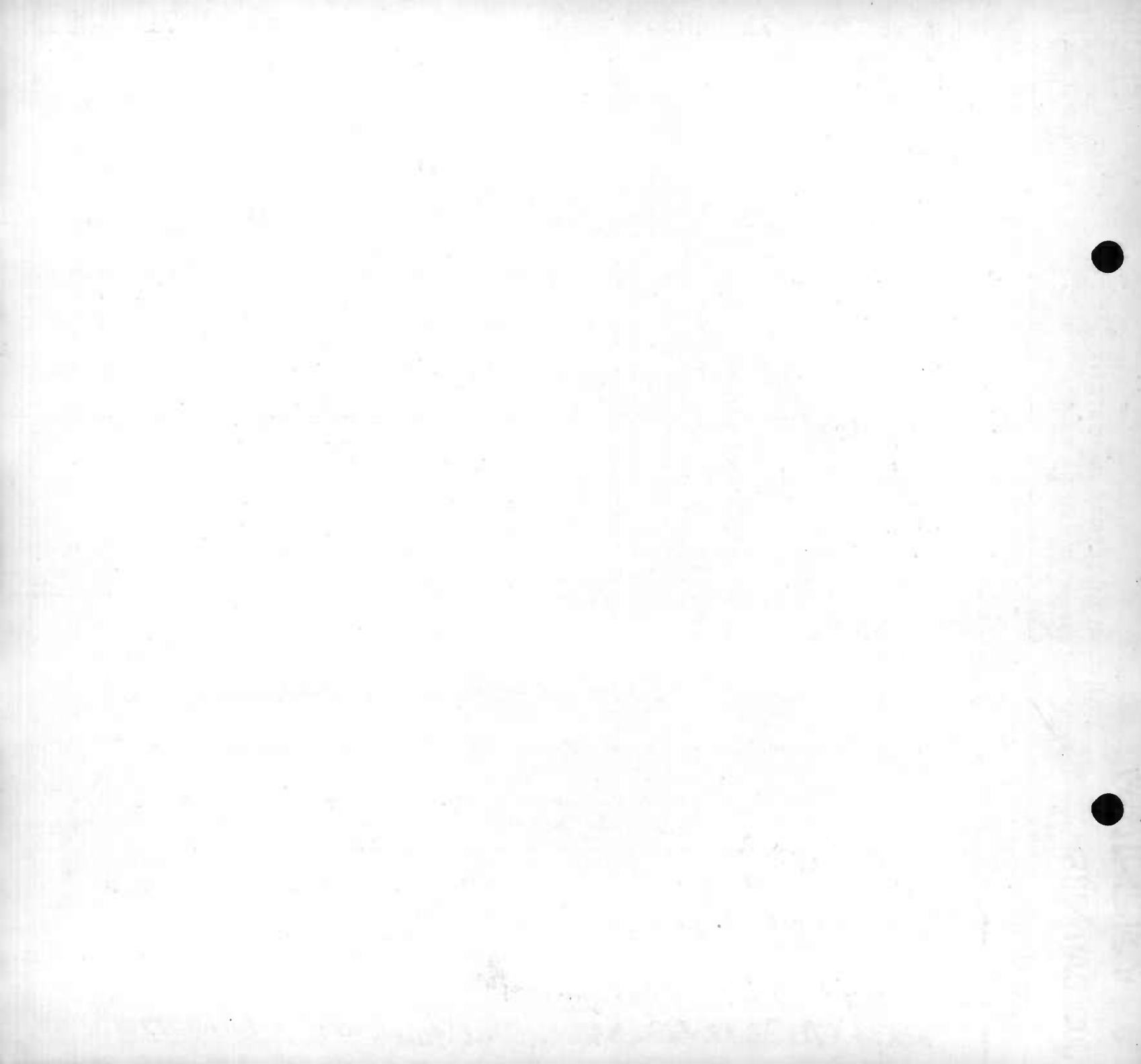
SEP 17 1951

WALL EX FORT

[Handwritten signature]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-462		71 4093		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 4093	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) CLARK, CLIFTON L. JR			
2. DATE AND HOUR OF DEATH 4/25/71 12:15 P.M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 802				5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 45 GOOD SAMARITAN HOSPITAL			
6. CITY OR TOWN BALTIMORE		7. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8. STREET AND NUMBER 1964 PERLMAN PLACE			
9. SEX MALE		10. RACE NEGRO		11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12. DATE OF BIRTH 8-19-1935	
13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed hairdresser for 10 years		14. KIND OF BUSINESS OR INDUSTRY		15. AGE (In years last birthday) 35		16. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
17. BIRTHPLACE (State or foreign country) VIRGINIA				18. CITIZEN OF WHAT COUNTRY? USA			
19. FATHER'S NAME CLARK, CLIFTON L. SR.				20. MOTHER'S MAIDEN NAME			
21. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				22. SOCIAL SECURITY NO. 229-46-9043		23. INFORMANT ADDRESS	
24. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				25. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 Hours			
26. MEDICAL CERTIFICATION 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				27. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CVA (B) PROSTHETIC MITRAL/AORTIC VALVES DUE TO, OR AS A CONSEQUENCE OF: (C) DIPHTHEROID - SBC			
28. 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		29. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		30. 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
31. 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		32. 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		33. 21F. HOW DID INJURY OCCUR?			
34. 22. I certify that (I) (this hospital) attended the deceased from 11 April 1971 to 25 April 1971, that (I) (we) lost saw the deceased alive on 1:30 PM (25 April) 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
35. 23A. SIGNATURE Thomas W. Lawhorne				36. 23B. DATE SIGNED 4/25/71		37. 23C. PHYSICIAN'S NAME (Type) THOMAS W. LAWHORNE	
38. 23D. ADDRESS Good Samaritan Hospital		39. 23E. DEGREE		40. 23F. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
41. 24A. BURIAL CREMATION, REMOVAL (Specify) Burial		42. 24B. DATE 4/30/71		43. 24C. NAME OF CEMETERY or CREMATORY Chatham		44. 24D. LOCATION (City, town, or county) (State) Chatham Va.	
45. 25A. DATE REC'D BY HEALTH DEPT. APR 27 1971		46. 25B. NAME OF REGISTRAR Robert E. J. J. J.		47. 25C. FUNERAL DIRECTOR Charles A. Rice		48. 25D. ADDRESS 661 W. Barre St	



71 4094		BALTIMORE CITY HEALTH DEPARTMENT		71 4094	
W-350		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO.	
BIRTH NO. 65-17640					
1. NAME OF DECEASED (Type or Print) Mischon D. Wooten Michelle D. Wooten		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 4 23 71 10:00 a.m.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 23 71 10:00 a.m.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1903	
6. SEX female	7. RACE Negro	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 7/14/65		10. AGE (In years lost birthday) 5		E. STREET AND NUMBER 1844 Eagle St.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Ernest Wooten, Jr.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Estelle Goodman	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.		17. SOCIAL SECURITY NO. None		18. INFORMANT Estelle Wooten 1844 Eagle St.	
19. E 814.7 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Multiple injuries		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) STREET		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Wilkins Ave. & Monroe St. 1903	
22D. TIME OF INJURY (APPROX.) 4 23 71 8:05 a.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject was crossing street when hit by car.	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Peter Lipkovic, MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/23/71	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/27/71		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary	
		24D. LOCATION (City, town, or county) (State) Brooklyn, Md.			
25A. DATE REC'D BY HEALTH DEPT. APR 27 1971		25B. NAME OF REGISTRAR Robert E. Fisher, MD		25C. FUNERAL DIRECTOR Charles A. Rice 661 W. Barre St.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 4095	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) WILLIAM F. LONG		2. DATE AND HOUR OF DEATH 4.26.71 3.30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CHURCH HOME AND HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY _____ C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3748 BONVIEW AVE. 26-43			
5. SEX M.	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10.16.12	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 58 If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min: _____	
11. BIRTHPLACE (State or foreign country) FLORIDA.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME R. F. LONG.		14. MOTHER'S MAIDEN NAME MINNIE JOHNS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 264-12-4112		17. INFORMANT _____ ADDRESS _____	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Unknown.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Diabetes Mellitus + severe general debility	
19A. DATE OF OPERATION 4.23.71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Rt. Scapula Nerve Rupture		20A. AUTOPSY? (Yes or No) _____	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4.17 19 71 to 4.26 19 71 that (I) (we) lost saw the deceased alive on 4.26 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Rustum. Irani MD.				23B. DATE SIGNED 4.26.71	
23C. PHYSICIAN'S NAME (Type) RUSTUM IRANI MD				23D. ADDRESS CHURCH HOME AND HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4-27-71		24C. NAME OF CEMETERY or CREMATOR ANATOMY BOARD OF MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. APR 28 1971		25B. NAME OF REGISTRAR Robert L. Taylor, Jr.		25C. FUNERAL DIRECTOR JOHNS HOPKINS MEDICAL SCHOOL MORTUARY SERVICE - BOWD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 4096
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
NEWELL W. MAJORS		4/22/71		7:30 P.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Md.		
6134 DUNROMING RD.		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 6134 DUNROMING RD. 27-38		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/9/1905	9. AGE (In years last birthday) 65
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Salisbury, Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Noah Majors		
14. MOTHER'S MAIDEN NAME Elizabeth Goslee		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 213 01 2077		17. INFORMANT Dorothy M. Majors 6134 Dunroming Rd.		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate 8 yrs		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from January 19 64 to April 22 19 71 that (I) (we) last saw the deceased alive on December 27 19 70 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE A. Allan Sier		23B. DATE SIGNED 4/23/71		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/26/71		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery
24D. LOCATION (City, town, or county) (State) Taylor Ave Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. APR 28 1971		
25B. NAME OF REGISTRAR Robert E. Taber, M.D.		25C. FUNERAL DIRECTOR Mitchell Wiedefeld Home 6500 York Rd.		

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 4097</u>
H-250 71 4097		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Margaret Hagin</u> <u>MARGARET HAGIN</u>		2. DATE AND HOUR OF DEATH <u>4-21-71</u> <u>4 35 P</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALT</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Union Memorial</u>		C. CITY OR TOWN <u>BALT</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>1149 GORSUCH</u> <u>9-05</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-2-95</u>	9. AGE (In years last birthday) <u>72</u> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>U.S.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>FREDERICK KAUFMANN</u>		
14. MOTHER'S MAIDEN NAME <u>Corla Woodrow</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>216-01-0365</u>		17. INFORMANT <u>Mrs. Dorothy Hicks</u> <u>1149 Gorsuch Ave</u>		
18. <u>450X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>PULMONARY EMBOLUS</u> (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 MIN</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>JULY 1968</u> to <u>APRIL 21</u> 19 <u>71</u> , that (I) (we) last saw the deceased alive on <u>4-17-71</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Frank X Carney</u>		23B. DATE SIGNED <u>4-21-71</u>		23C. PHYSICIAN'S NAME (Type) <u>FRANK X CARNEY</u>
23D. ADDRESS <u>3201 N Charles</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>4/26/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Baltimore National</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>APR 28 1971</u>		25B. NAME OF REGISTRAR <u>John E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Mitchell-Wiedefeld Home, Inc.</u>

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-624		71 4098		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 4098	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>Cosbie C. Trusley</u>			
2. DATE AND HOUR OF DEATH <u>5⁰⁰ AM 4/24/71</u>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>BALTIMORE CITY HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
4940 Eastern Ave., Baltimore, Maryland 21224				C. CITY OR TOWN <u>Dundalk</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER <u>1929 Searles Road</u>				21222 <u>5300</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/7/09</u>	9. AGE (In years last birthday) <u>62</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Eaf Little</u>				14. MOTHER'S MAIDEN NAME <u>Ann Hall</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Records: BCH-4940 Eastern Avenue</u>				ADDRESS <u>21224</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Gangrene of small bowel</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Occlusion superior mesenteric artery</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Diffuse arteriosclerosis</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>4/22/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Intestinal Gangrene / Obstruction</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>4/24</u> 19 <u>71</u> to <u>4/24</u> 19 <u>71</u> that (I) (we) lost saw the deceased alive on <u>4/24 (5AM)</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>(did)</u> (did not) view the body after death.							
23A. SIGNATURE <u>John M. Kellum, Jr.</u>				23B. DATE SIGNED <u>4/24/71</u>		23C. PHYSICIAN'S NAME (Type) <u>John M. Kellum, Jr.</u>	
23D. ADDRESS <u>4940 Eastern Avenue</u>				23E. CITY, TOWN, OR COUNTY <u>Baltimore, Maryland</u>		23F. STATE <u>21224</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-26-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Dorsey, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 28 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>John J. Duda</u>		ADDRESS <u>7922 Wise Ave. Dundalk, Md.</u>	

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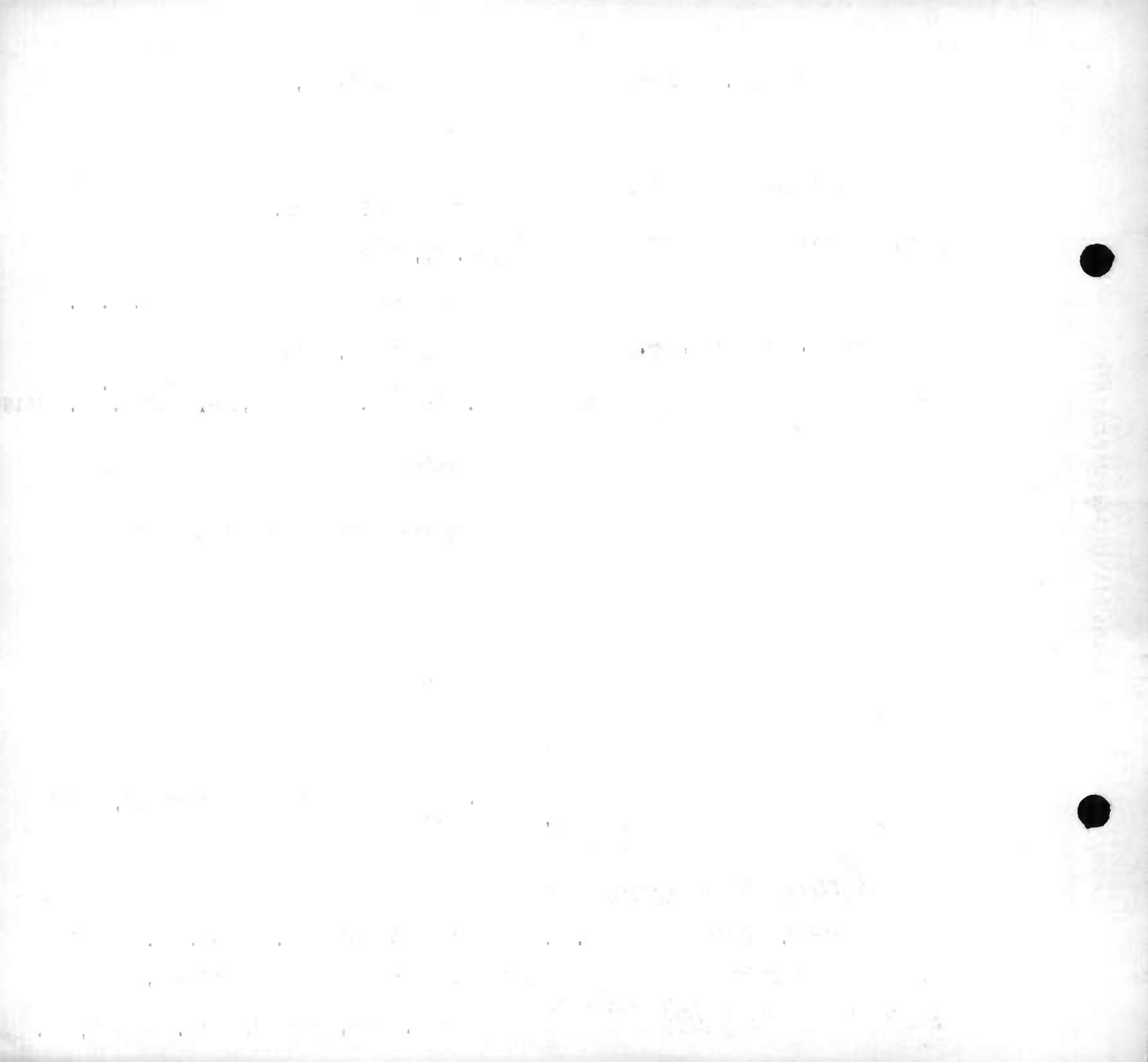
4/2/58

4/2/58

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4099		
BIRTH NO. M-265		71 4099		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) James P. McCormack			2. DATE AND HOUR OF DEATH April 23, 1971			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Edgemere D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 2412 Carolyne Ave. 53-00			
5. SEX Male		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH Feb. 21, 1964			9. AGE (In years last birthday) 7		10. KIND OF BUSINESS OR INDUSTRY Dependent	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent			11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edward J. McCormack, Sr.			14. MOTHER'S MAIDEN NAME Alvina E. Blimline			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT (Father) 2412 Carolyne Ave. Mr. Edward J. McCormack, Sr. Balto. Md. 21219	
18. CAUSE OF DEATH						
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <div style="text-align: center; font-weight: bold;">II</div> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden Life		
19A. DATE OF OPERATION None				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None		
20A. AUTOPSY? (Yes or No) No				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Cardiac Defect - SEPTAL			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) None			21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) None			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR? None			
22. I certify that (I) (this hospital) attended the deceased from Feb. 19 64 to April 23, 19 71 that (I) last saw the deceased alive on April 23, 19 71 and that in (my) (our) opinion death occurred on the date April 23, 19 71 and hour and from the causes stated above. (I) (we) (do) (did not) view the body after death.						
23A. SIGNATURE Louis N. Tollin M.D.					23B. DATE SIGNED 4/24/71	
23C. PHYSICIAN'S NAME (Type) Louis N. Tollin M. D.			23D. ADDRESS 6908 North Point Rd. Balto. Md. 21219			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/26/71		24C. NAME OF CEMETERY OR CREMATORY Holly Hill Memorial Gardens		
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. APR 28 1971				
25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR ADDRESS John J. Duda, 7922 Wise Ave. Dundalk, Md.				



71 4100

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 4100

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Ruth M. Kesecker		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 236 S. Mount Olive La.		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 24 71 9:25 a M.	
6. SEX female		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 7-6-1923		10. AGE (In years lost birthday) 47 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Mary A. Wafer		18. INFORMANT Mr. John A. Keamer III	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 215-18-0907	
19. CAUSE OF DEATH 571.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Fatty alteration of liver (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Werner U. Spitz M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/25/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-28-1971	
24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 28 1971		25B. NAME OF REGISTRAR Robert E. [unclear]	
25C. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave. 21229	

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FUNERAL DIRECTOR: IMPORTANT

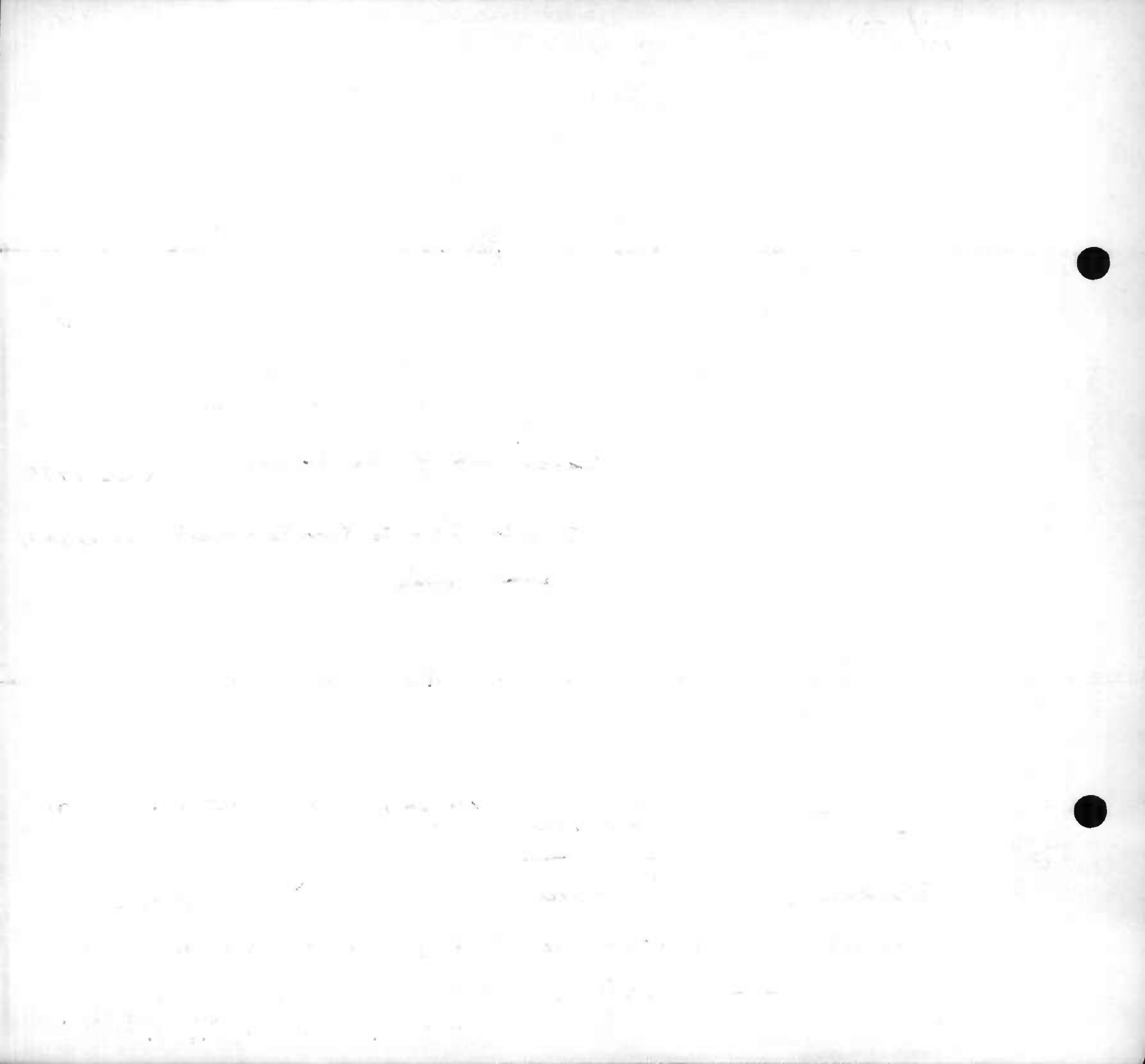
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 4101		71 4101	
K-236				CERTIFICATE OF DEATH			
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) KOSTER FRANK				2. DATE AND HOUR OF DEATH APRIL 19, 1971 9¹⁰ A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL HOSPITAL				A. STATE Md.		B. COUNTY 1	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1214 Eutaw Place		17-02	
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> ? DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-18-89	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?		10B. KIND OF BUSINESS OR INDUSTRY ?		11. BIRTHPLACE (State or foreign country) ?		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ?				16. SOCIAL SECURITY NO. 070-077199		17. INFORMANT HOSPITAL RECORDS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 DAYS			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASPIRATION PNEUMONIA			
				(B) CHRONIC OBSTRUCTIVE PULMONARY DIS. DUE TO, OR AS A CONSEQUENCE OF:			
				(C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). HYPERTENSIVE CARDIOVASCULAR DISEASE							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from April 16, 1971 to April 19, 1971 that (I) (we) last saw the deceased alive on April 19, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Wm. D. Hakkarinen MD				23B. DATE SIGNED 4-19-71			
23C. PHYSICIAN'S NAME (Typol) WILLIAM D. HAKKARINEN MD				23D. ADDRESS MD. GENERAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/24/71		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 28 1971		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR William E. Johnson		ADDRESS 8521 Loch Raven Blvd Baltimore, Md. 21204	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 4102	
BIRTH NO. 71 4102		DATE AND HOUR OF DEATH 4-18-71 7:15 AM	
1. NAME OF DECEASED (Type or Print) SHERMAN MACKEY		2. DATE AND HOUR OF DEATH	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) KEY CIRCLE HOSPICE		A. STATE MD B. COUNTY BALTO	
5. SEX M 6. RACE C		C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 1305 TEN PEN ALLEY 3-01	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNKNOWN		9. AGE (in years last birthday) 69	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) UNKNOWN	
13. FATHER'S NAME ERNEST EDWARD MACKEY		12. CITIZEN OF WHAT COUNTRY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
16. SOCIAL SECURITY NO. 219-05-3266		17. INFORMANT ADDRESS Key Circle Hospice Records	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Carcinoma of the Lung ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE Metastatic to Parotid gland (B) DUE TO, OR AS A CONSEQUENCE OF: and chain (C) Dec 1970 Dec 1971		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 14 Jan 1971 to 15 Apr 1971 that (I) (we) last saw the deceased alive on 15 Apr 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Michael S. Mishkin MD		23B. DATE SIGNED 19 Apr 71	
23C. PHYSICIAN'S NAME (Type) Michael S. Mishkin MD		23D. ADDRESS 1855 greenberry Rd Balto MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-23-71	
24C. NAME OF CEMETERY OR CREMATORY Mount Calvary Cemetery		24D. LOCATION (City, town, or county) (State) Anna Arundel County, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 28 1971		25B. NAME OF REGISTRAR William E. Johnson	
25C. FUNERAL DIRECTOR 8521 Loch Raven Blvd. Balto., Md. 21204		25D. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

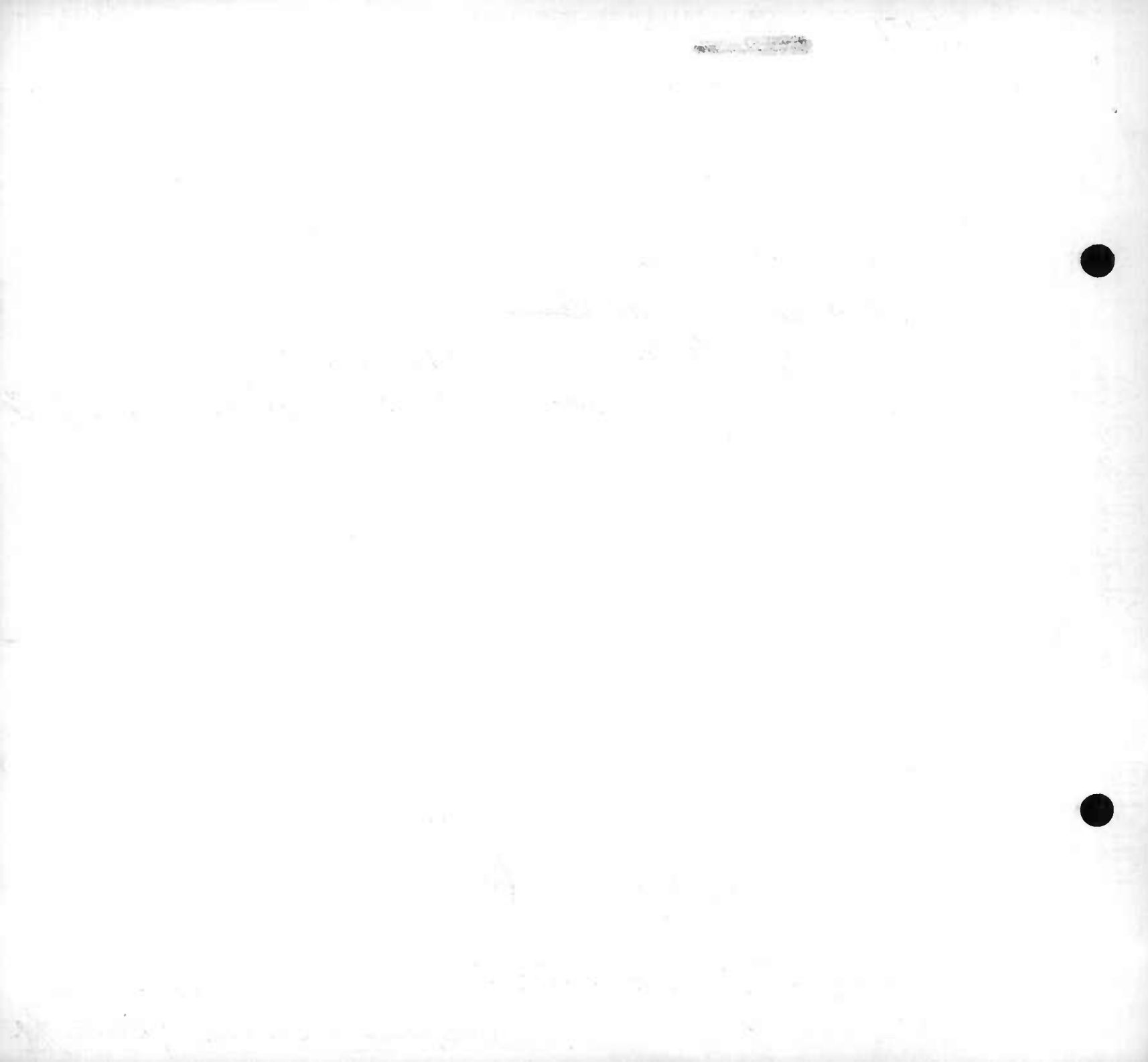
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-160 71 4103				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 4103	
1. NAME OF DECEASED (Type or Print) <i>Biber, SARAH</i>				2. DATE AND HOUR OF DEATH <i>4-25-71 10:40 PM</i>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <i>Sinai Hospital of Baltimore</i>				A. STATE <i>Maryland</i>		B. COUNTY		C. CITY OR TOWN <i>Baltimore</i>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <i>2906 Oakton St. 53-00</i>			
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>XXXXXX</i>		9. AGE (In years last birthday) <i>67</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFFICE				10B. KIND OF BUSINESS OR INDUSTRY RETAIL		11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME MAX BIBER				14. MOTHER'S MAIDEN NAME UNKNOWN					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 218-07-3621		17. INFORMANT MRS. SYLVIA RESNICK, 2906 OAKTON CT. #21209			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <i>metastatic Brain Tumor</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Brain Cancer</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION <i>4-25</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that <i>40</i> (this hospital) attended the deceased from <i>3-16</i> 19 <i>71</i> to <i>4-28</i> 19 <i>71</i> that <i>40</i> (we) last saw the deceased alive on <i>4-25</i> 19 <i>71</i> and that <i>in (my)</i> (our) opinion death occurred on the date and hour and from the causes stated above. <i>40</i> (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Rodolfo S. Victoria MD</i>				23B. DATE SIGNED <i>4-25-71</i>					
23C. PHYSICIAN'S NAME (Type) <i>Rodolfo S. Victoria MD</i>				23D. ADDRESS <i>Sinai Hospital of Baltimore</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE <i>4-26-71</i>		24C. NAME OF CEMETERY OR CREMATORY ADATH YESHURUN		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. <i>APR 28 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, MD</i>		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		ADDRESS			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

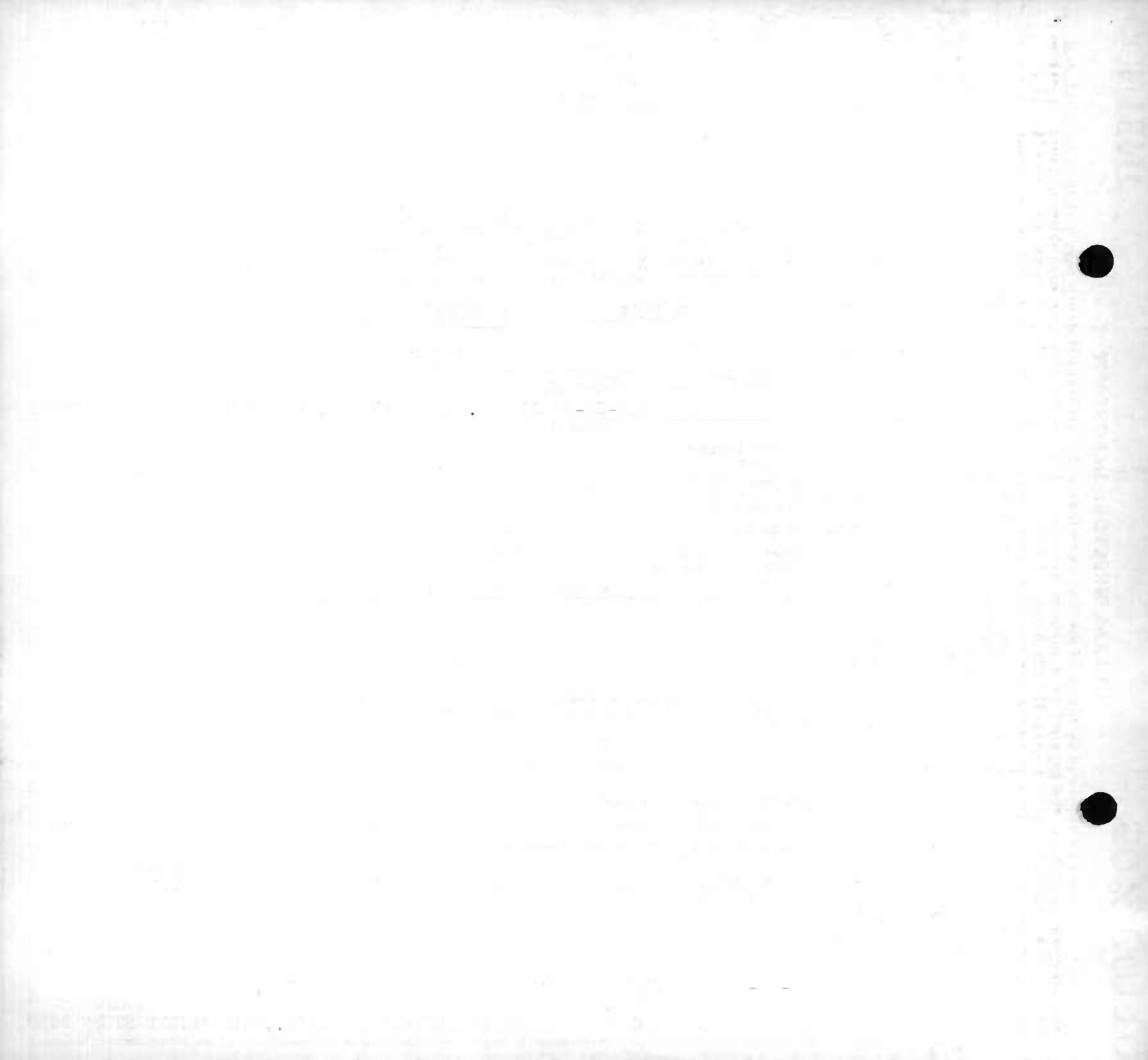
B-151		71 4104		BALTIMORE CITY HEALTH DEPARTMENT		71 4104	
CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print) RACHEL RUBINOFF				2. DATE AND HOUR OF DEATH 4.25.71 12.50 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital of Md.				A. STATE MD.		B. COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2510 Taney Rd.		27-40	
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 06-10-84	9. AGE (in years last birthday) 86	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) AUSTRIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Phillips Reiss				14. MOTHER'S MAIDEN NAME Blondie ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Mrs. Helen B. Ashman - 2510 Taney Rd.			
				ADDRESS			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction				4 days.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebro Vascular Accident.			
				(B) DUE TO, OR AS A CONSEQUENCE OF: ASCVD			
				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 4/24/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED no		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) no		21C. WHERE DID INJURY OCCUR? no		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) no		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? no			
22. I certify that (I) (this hospital) attended the deceased from 4/22/71 19 71 to 4/25/71 19 71 that (I) (we) last saw the deceased alive on 4/25/71 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE C. G. AKUBA				23B. DATE SIGNED 4.25.71		23C. PHYSICIAN'S NAME (Type) C. G. AKUBA	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/26/71		24C. NAME OF CEMETERY St. David - Elmont Long Island New York		24D. LOCATION (City, town, or county) (State) Baltimore 21216	
25A. DATE REC'D BY HEALTH DEPT. APR 28 1971		25B. NAME OF REGISTRAR Robert E. Fisher, R.D.		25C. FUNERAL DIRECTOR John F. Brown & Son 6010 Fustatoun Rd.		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

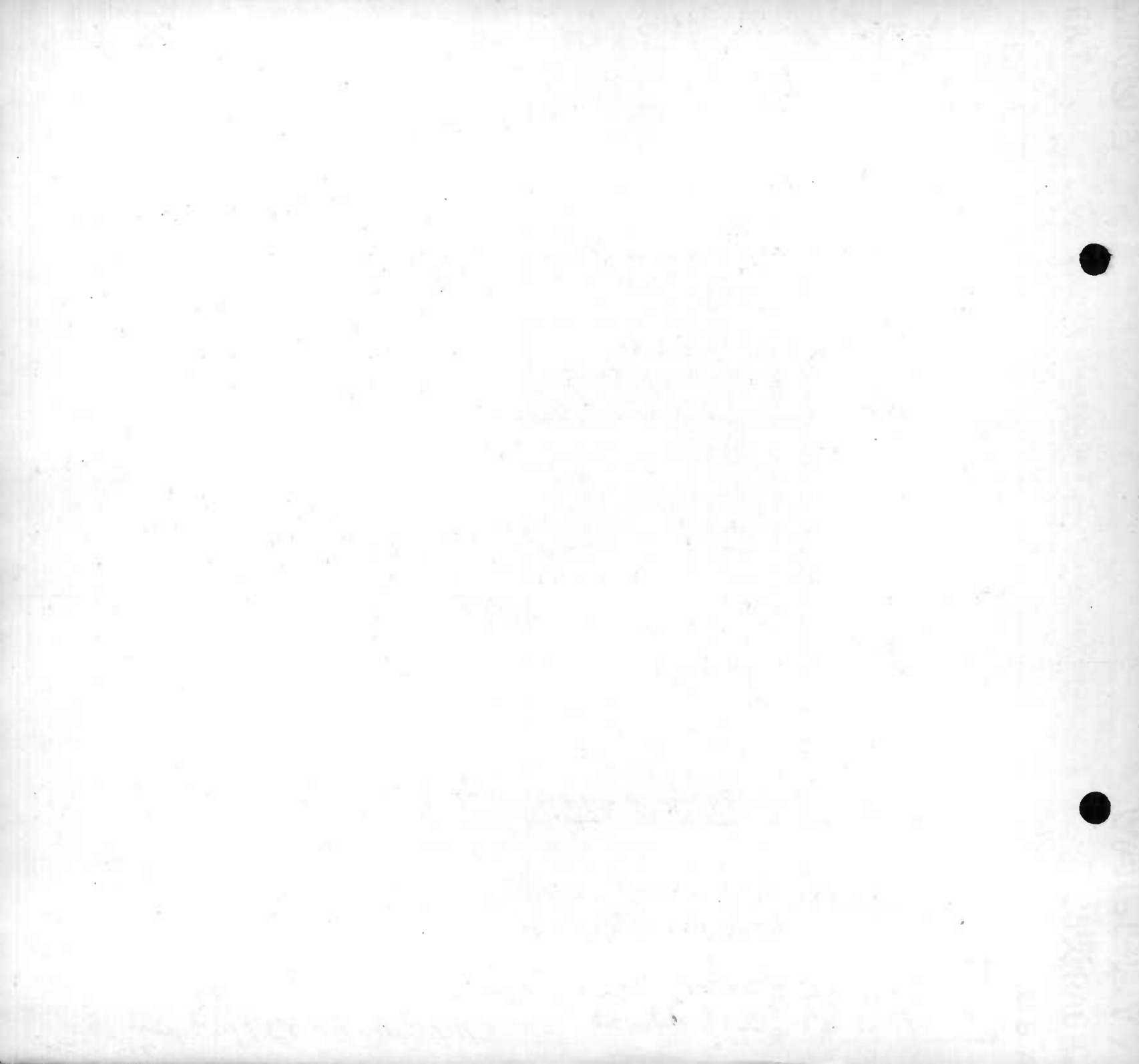
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4105	
E-535 71 4105		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Entner, Florence F.</i>		2. DATE AND HOUR OF DEATH <i>4-21-71 4:25 P M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Sinai Hospital & Bethel</i>		C. CITY OR TOWN <i>Bethel</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>FEMALE</i>		6. RACE <i>W HITE</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>		8. DATE OF BIRTH <i>XXXXXXXXXX</i>	
11. BIRTHPLACE (State or foreign country) <i>RUSSIA</i>		9. AGE (in years last birthday) <i>XX 69</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME <i>ISAAC ZUCK</i>		14. MOTHER'S MAIDEN NAME <i>JENNIE</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>212-34-8992A</i>		17. INFORMANT <i>MR. ALVIN ENTNER, 1916 RAMSEY STREET #21223</i>	
18. <i>41231</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Severe Chronic Angeroid Heart failure</i>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Angeroid Heart Disease</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>4-21-71</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <i>4-19-71</i> to <i>4-21-71</i> and that (2) (we) last saw the deceased alive on <i>4-21-71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (2) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Rodolfo S. Victoria MD</i>		23B. DATE SIGNED <i>4-21-71</i>			
23C. PHYSICIAN'S NAME (Type) <i>Rodolfo S. Victoria MD</i>		23D. ADDRESS <i>Sinai Hospital of Bethel</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>4-25-71</i>		24C. NAME OF CEMETERY OR CREMATORY <i>AHAVAS SHALOM</i>	
24D. LOCATION <i>ROSEDALE, MARYLAND</i>		25A. DATE REC'D BY HEALTH DEPT. <i>APR 28 1971</i>			
25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

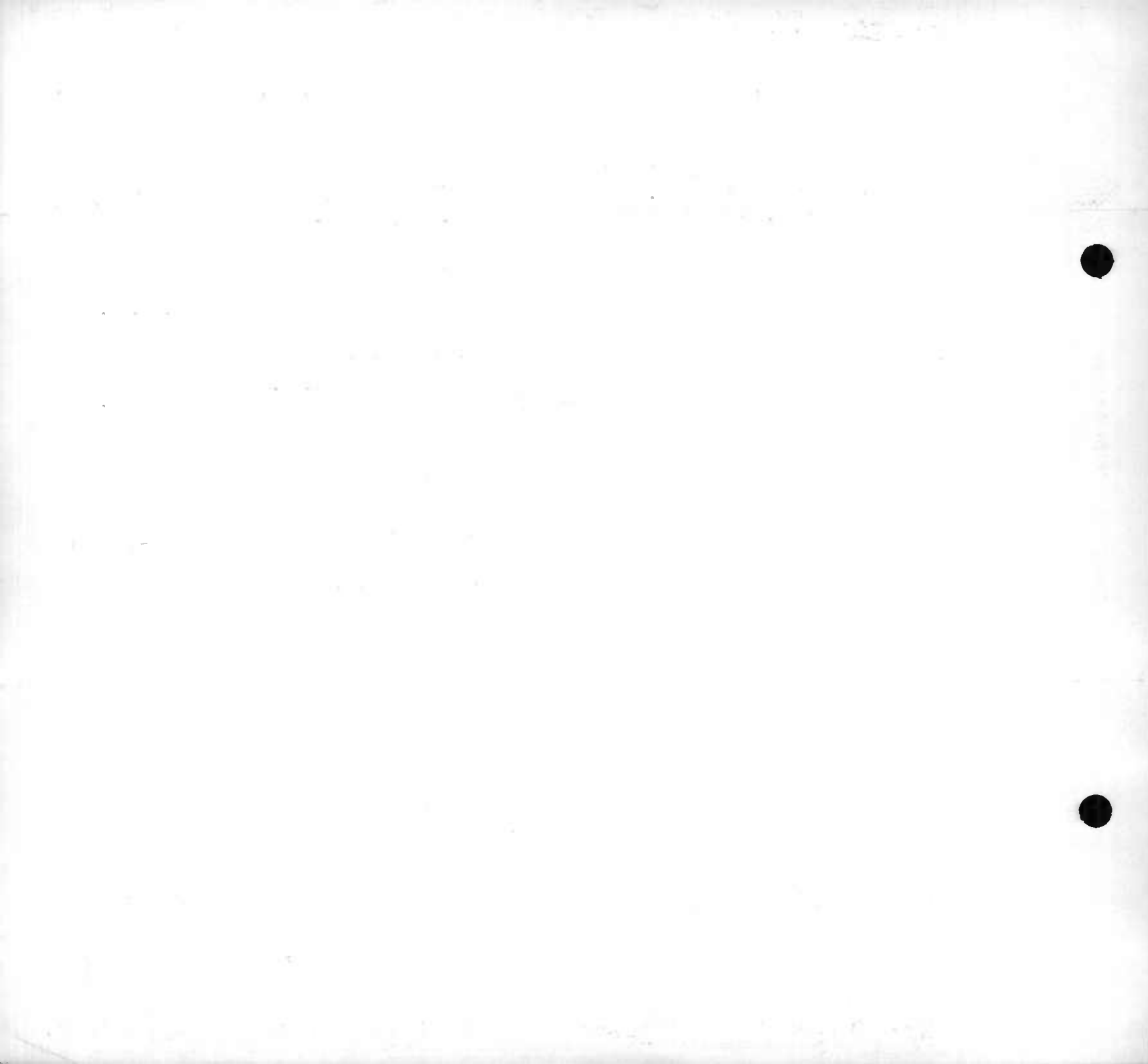
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4106	
BIRTH NO. 1-456		71 4106		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) DILEONARDI PAULINE		2. DATE AND HOUR OF DEATH 4/26/71 7:24 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SOUTH BALTIMORE GENERAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore			
5. SEX F 6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-4-88	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 82	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME CARL SALA		14. MOTHER'S MAIDEN NAME MICHELINA LAROSA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-05-5875-D		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CONGESTIVE HEART FAILURE (B) DUE TO, OR AS A CONSEQUENCE OF: ARTERIO-SCLEROTIC-CARDIO-3 yrs. (C) VASCULAR DISEASE ATRIAL FIBRILLATION		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years. 1 year.	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-17-1971 to 4/26/1971 that (I) (we) last saw the deceased alive on 4/26/1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harjit Singh M.D.		23B. DATE SIGNED 4/26/71		23C. PHYSICIAN'S NAME (Type) HARJIT SINGH	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/30/71		24C. NAME OF CEMETERY or CREMATORY HOLY CROSS CEM	
24D. LOCATION (City, town, or county) Baltimore		24E. ADDRESS 3001 S. HANDOVER ST. BALTO MD			
25A. DATE REC'D BY HEALTH DEPT. APR 28 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR McCallum F.H. 137 Parkway Ave	
25D. ADDRESS 71245					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 4107	
H-253 71 4107				CERTIFICATE OF DEATH	
BIRTH NO.				REG. NO.	
1. NAME OF DECEASED (Type or Print) HIGHSMITH, JULIUS BEN			2. DATE AND HOUR OF DEATH April, 21, 1971 5:10 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Veterans Administration Hospital IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 3900 Loch Raven Blvd. Baltimore, Maryland 21218			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 7 S. Popplin St.		
5. SEX Male	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2-22-04	9. AGE (in years last birthday) 67	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) North Carolina			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME R. Louis Highsmith			14. MOTHER'S MAIDEN NAME Magnolia Goney Carney		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 12-14-41 to 7-22-42			16. SOCIAL SECURITY NO. 212-12-12-321		
17. INFORMANT Records V. A. Hospital			ADDRESS 3900 Loch Raven Blvd., Baltimore, Md.		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ? 2-4 years cardiovascular disease
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that OS (this hospital) attended the deceased from April 13, 1971 to April 21, 1971 that X (we) last saw the deceased alive on April 21, 1971 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. OS (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Richard V. Mallon MD</i>				23B. DATE SIGNED 4/22/71	
23C. PHYSICIAN'S NAME (Type) Richard V. Mallon				23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/27/1971		24C. NAME of CEMETERY or CREMATORY Gettysburg National Cemetery	
24D. LOCATION Gettysburg, Pa.		25A. DATE REC'D BY HEALTH DEPT. APR 28 1971			
25B. NAME of REGISTRAR John E. Smith, R.D.		25C. FUNERAL DIRECTOR Eugenia K. Seitz			
25D. ADDRESS 5209 York Road Balto Md.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4108	
R-452 71 4108		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Ruby Rawlings (Hunter)		2. DATE AND HOUR OF DEATH 4/26/71 10 20 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Mercy		A. STATE Md		B. COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1131 Greenmount AVE 10-01			
5. SEX F	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-15-26	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 45	
11. BIRTHPLACE (State or foreign country) N. Carolina		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Butley Hunter		14. MOTHER'S MAIDEN NAME Aureta Jones			
15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Patient	
18. 174X I		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH [This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.]		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Septicemia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Breast Abscess = Erysipelas (Chest) DUE TO, OR AS A CONSEQUENCE OF:		? 5 months	
		(C) Ca @ Breast		1-5 years	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/22/71 19 71 to 4/26/71 19 71 that (I) (we) last saw the deceased alive on 4/26 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lloyd B. Mandel MD		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4/27/71	
23C. PHYSICIAN'S NAME (Type) Lloyd B. Mandel MD		23D. ADDRESS Mercy Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5/1/71		24C. NAME OF CEMETERY OR CREMATORY MT AUBURN CEMETERY	
24D. LOCATION (City, town, or county) (State) BALTIMORE MD		25A. DATE REC'D BY HEALTH DEPT. APR 28 1971			
25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR DONALD E. GLOVER 170 N. PATTERSON PARK			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Underdetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department		REG. NO. 71 4109	
BIRTH NO. H-520		71 4109	
1. NAME OF DECEASED (Type or Print) ELIZABETH HINES		2. DATE AND HOUR OF DEATH 4-21-71 10.25 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL		A. STATE MARYLAND B. COUNTY BALTIMORE CITY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1035 ORLEANS STREET	
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-05-99
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) 70
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SANDY STAPLES		14. MOTHER'S MAIDEN NAME HENRIETTA STAPLES	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. 228-20-9104	
17. INFORMANT Ruth Lee Johnson		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cardiac Arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Asthma DUE TO, OR AS A CONSEQUENCE OF: 2 days	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Chronic Bronchitis			
19A. DATE OF OPERATION 4/21	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 4/18 19 71 to 4/21 19 71 that (1) (we) last saw the deceased alive on 4/21 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Richard L. Taw Jr MD		23B. DATE SIGNED 4/22/71	
23C. PHYSICIAN'S NAME (Type) RICHARD L. TAW, JR.		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 4-26-71	24C. NAME OF CEMETERY OR CREMATORY Mt. CALVARY CEM	24D. LOCATION (City, town, or county) (State) ARUNDEL CO. MD
25A. DATE REC'D BY HEALTH DEPT. APR 28 1971		25B. NAME OF REGISTRAR Robert E. Taylor	25C. FUNERAL DIRECTOR E.O. WILSON
		ADDRESS 1000 BRANTLEY AVE.	

25-12-1971 (1971)

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THE JOHN H. HARRIS FOUNDATION

1971-12-25

1971-12-25

71 4110 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 71 4110

B-256
BIRTH NO. 68-20607

REG. NO. 71 4110

1. NAME OF DECEASED (Type or Print) JOYCE BUCKNER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. 3. DATE PRONOUNCED DEAD Month Day Year Hour April 23, 1971 8:10 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) JOHNS HOPKINS HOSPITAL (DOA)		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
6. SEX Female	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH 10-21-68		10. AGE (In years last birthday) 2 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		13. FATHER'S NAME John E. Buckner 15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Minnie Buckner Lewis		ADDRESS	
19. 480X1 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Viral pneumonitis (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Purulent otitis media			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-27-71	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cmt		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. APR 28 1971		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Ed Wilson		ADDRESS 1000 Broadway	

DATE SIGNED **4/24/71**

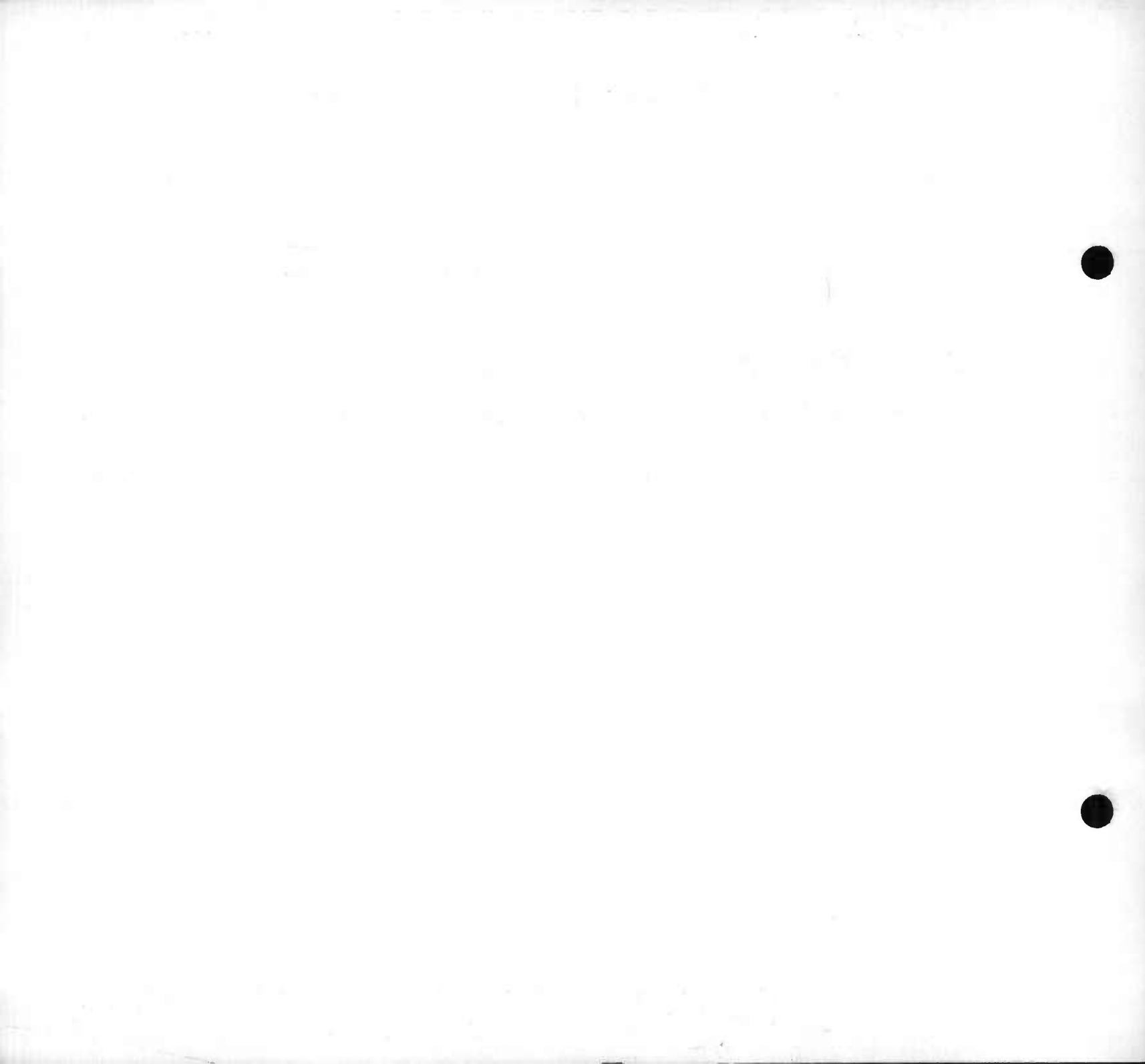
VS 151-REV. 1/1/68

5-13-71 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

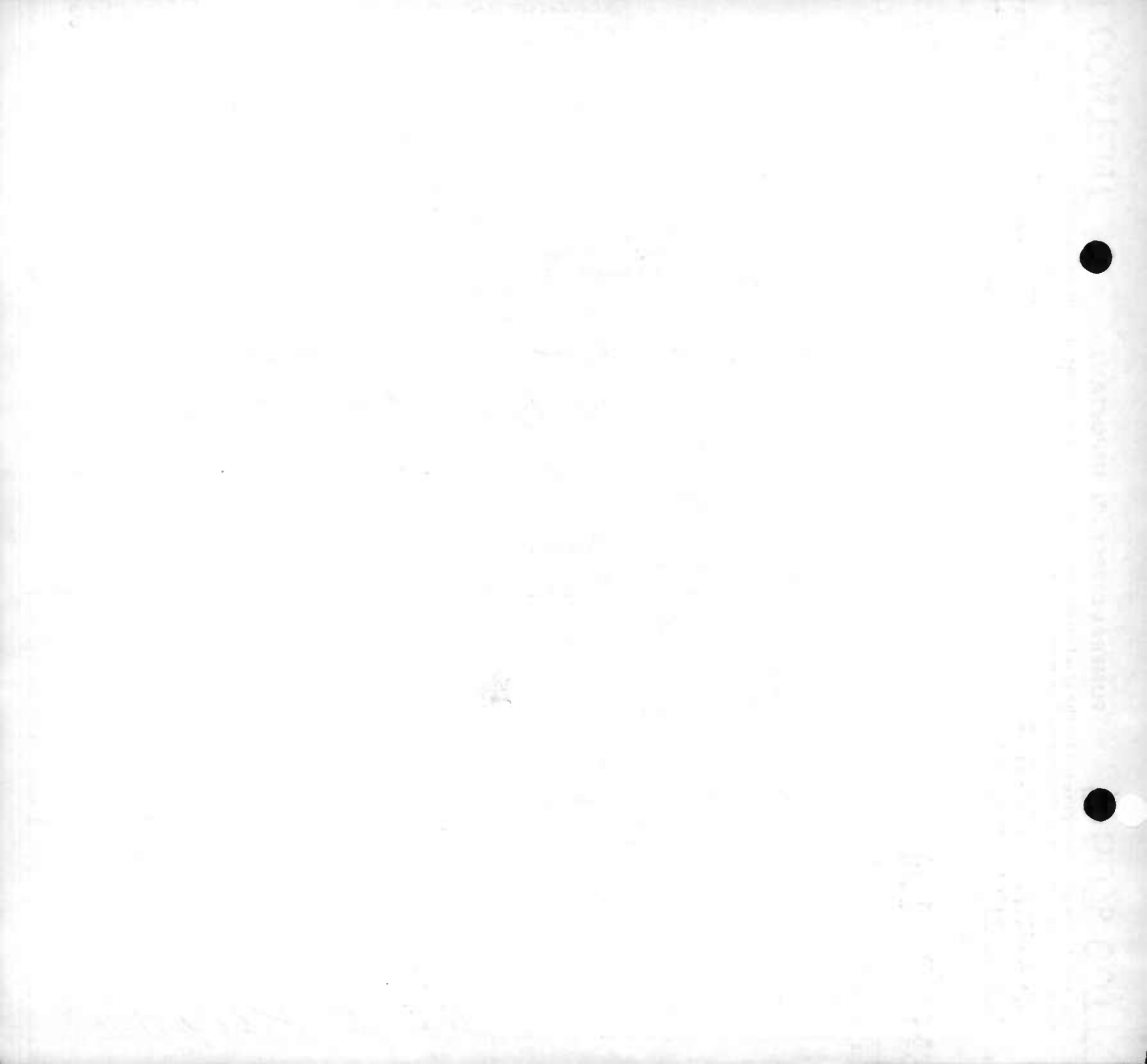
P-422 71 4111		BALTIMORE CITY HEALTH DEPARTMENT		71 4111	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>Walter M. Pilachowski</u>			2. DATE AND HOUR OF DEATH <u>4/27/71</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Maryland General Hosp</u>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u>		
5. SEX <u>M</u>			6. RACE <u>C</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Longshoreman</u>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>1/7/27</u>	
13. FATHER'S NAME <u>MARTIN PILACHOWSKI</u>		14. MOTHER'S MAIDEN NAME <u>BERTHA WOJCIECHOWSKI</u>		9. AGE (In years lost birthday) <u>44</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES WW II</u>		16. SOCIAL SECURITY NO. <u>214-20-0053</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
18. <u>130X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION LAST		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Renal Insufficiency</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
		(B) <u>Esophagogastrectomy</u> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5d</u>	
		(C) <u>Carcinoma Esophagogastrectomy</u>		<u>3 mo (?)</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>4/21 & 4/23</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Carcinoma Esoph/gastric junct</u>		20A. AUTOPSY? (Yes or No) <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/14</u> 19 <u>71</u> to <u>4/27</u> 19 <u>71</u> that (I) (we) lost saw the deceased alive on <u>4/27/71</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>James Henry MD</u>			23B. DATE SIGNED <u>4/27/71</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <u>James Henry</u>			23D. ADDRESS <u>MARYLAND GENERAL</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4-30-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>GARDENS OF FAITH CEM.</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 28 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Jones, R.D.</u>	
25C. FUNERAL DIRECTOR <u>John Meher & Sons</u>		ADDRESS <u>100 S. Charles St.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-000 71 4112				BALTIMORE CITY HEALTH DEPARTMENT		71 4112	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Shaw, M'essie Mae				4-25-'71 11:50 p.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY			
Sinai Hospital of Balt. Inc.				Maryland Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				3906 W. Garrison Ave. #152798			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
Female		N.				8/24/18	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Custodian				SCHOOL		North Carolina	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Charles Faulcon				Ann Young			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
				217-12-5463		Ernest Shaw 1411 Denison St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Septic Gram. Negative Shock				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		About one Month	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) _____	
Perforated Cecal Diverticulum							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
3/18/71		guard's pool					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 3-18 1971 to 4-25 1971 that (I) (we) last saw the deceased alive on 4-25 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
Dr. Cheryl Lee M.D.				4-25-'71			
23D. ADDRESS				23E. PHYSICIAN'S DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		4/29/71		Arbutus Mem. Park		Baltimore Md.	
25A. DATE RECD. BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 28 1971				Arbutus Mem. Park		1727 N. Meigs	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-522		71 4113		BALTIMORE CITY HEALTH DEPARTMENT		71 4113	
BIRTH NO.				ANUSZEWSKI			
1. NAME OF DECEASED (Type or Print) Andrew Anuszevski				2. DATE AND HOUR OF DEATH April 27 1971 11:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Church Home & Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Church Home & Hospital				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1725 Fleet St				203			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12 September, 1896		9. AGE (In years last birthday) 74	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATCHMAN		10B. KIND OF BUSINESS OR INDUSTRY ARUNDEL CORP.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ANDREW ANUSZEWSKI				14. MOTHER'S MAIDEN NAME CATHERINE ANUSZEWSKI			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 218-10-5534		17. INFORMANT FRANK LUBAWSKI		ADDRESS 1725 FLEET ST.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE Possible bronchogenic carcinoma due to, or as a consequence of: metastasis to the brain. (B) Pneumonia due to, or as a consequence of: (C)			
19A. DATE OF OPERATION 4/26/71				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/8 1971 to 4/26 1971 that (I) (we) last saw the deceased alive on 4/26 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE A.E. Chouvalit, M.D.				23B. DATE SIGNED 4/26/71		23C. PHYSICIAN'S NAME (Type) A.E. CHOUVALIT, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/29/71		24C. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER CEM.		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. APR 28 1971		25B. NAME OF REGISTRAR Jesse E. Kelly, Jr.		25C. FUNERAL DIRECTOR WM. FIALKOWSKI 2007 EASTERN AVE.			

1974

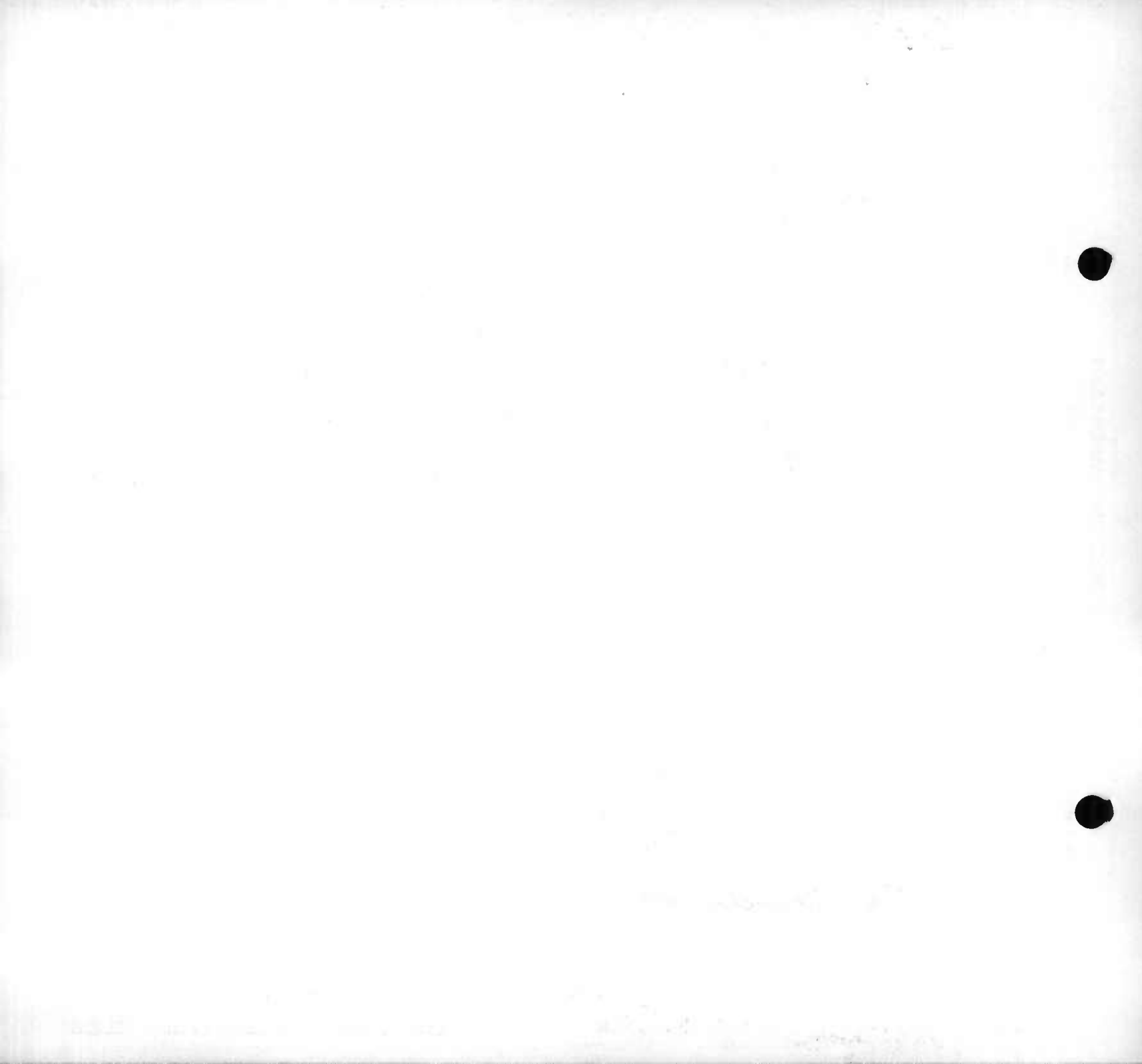
1974

1974

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>Collins, Ethel O.</u>		2. DATE AND HOUR OF DEATH <u>4/24/71</u> <u>10:30</u> p. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Bolton Hill Nursing Home</u> <u>1400 John St.</u> <u>Baltimore, Md. 21217</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland, Baltimore</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1029 Boyd Street</u> <u>1803</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/17/91</u>	9. AGE (in years lost birthday) <u>79</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Charles Collins</u>		14. MOTHER'S MAIDEN NAME <u>Julie McKenzie</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-03-7099</u>		17. INFORMANT <u>Admission Record</u>	
18. <u>75671</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Pneumonia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pneumonia</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>two days</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <u>September 1</u> 19 <u>67</u> to <u>April 24</u> 19 <u>71</u> that (X) (we) last saw the deceased alive on <u>April 24</u> 19 <u>71</u> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Peter H. Rheinstein, MD</u> DEGREE _____				23B. DATE SIGNED <u>28 April 1971</u>	
23C. PHYSICIAN'S NAME (Type) <u>Peter H. Rheinstein, MD</u>		23D. ADDRESS <u>Bolton Hill Nursing Home</u> DEGREE _____			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/28/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Cedar Hill</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 28 1971</u>			
25B. NAME OF REGISTRAR <u>John E. Witzke, Jr.</u>		25C. FUNERAL DIRECTOR <u>Witzke, 1630 Edmondson Avenue</u> ADDRESS <u>21228</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4115	
BIRTH NO. F-340		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) THERESA FEDELE			2. DATE AND HOUR OF DEATH 4/26/71 8⁵⁵ P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Gould Convalesarium			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Md B. COUNTY _____ C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5604 Belle Vista 2734		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 1, 1892	9. AGE (In years last birthday) 78	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10B. KIND OF BUSINESS OR INDUSTRY None			11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME UNK MASTRANGELO			14. MOTHER'S MAIDEN NAME Mary Louise Mastangello		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) None			16. SOCIAL SECURITY NO. 213-09-1027		17. INFORMANT GRACE Sullastio
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Myocardial Infarction		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertension			(B) DUE TO OR AS A CONSEQUENCE OF: Acute Coronary Artery Disease		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Arteriosclerosis, Heart Disease, Diabetes			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hours 18 hours 4 days unknown		
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None		20A. AUTOPSY? (Yes or No) None	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) None	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) None		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? None	
22. I certify that (I) (this hospital) attended the deceased from 4/21/71 to 4/26/71 , that (I) (we) last saw the deceased alive on 4/26/71 and that in (my) (our) opinion death occurred on the date 4/26/71 and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Albert B Bradley				23B. DATE SIGNED 4/26/71	
23C. PHYSICIAN'S NAME (Type) None				23D. ADDRESS None	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/29/71		24C. NAME OF CEMETERY OR CREMATORY Gould Convalesarium	
24D. LOCATION (City, town, or county) (State) Baltimore Md		25A. DATE REC'D BY HEALTH DEPT. APR 28 1971 25B. NAME OF REGISTRAR None 25C. FUNERAL DIRECTOR Joseph J. Zimm 25D. ADDRESS 263 S. Conkling			

17
The following is a list of the names of the persons who have been elected to the office of the

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 4116</u>	
1. NAME OF DECEASED (Type or Print) ANDREW AMES		2. DATE AND HOUR OF DEATH 4-21-71 10:45 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY OF MARYLAND HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 455 WALTON CT. 1702			
5. SEX MALE	6. RACE BLACK	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-12-46	9. AGE (In years last birthday) 25	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed-Porter		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME Milton Ames			
14. MOTHER'S MAIDEN NAME LILLIAN AMES 455 WALTON CT.		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK.			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MOTHER 455 Walton Court			
18. 320.1 I CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: HYPERKALEMIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 DAYS
			(B) ACUTE RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF:		4 DAYS
			(C) PNEUMOCOCCAL MENINGITIS		6 DAYS
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-16 19 71 to 4-20 19 71 that (I) (we) last saw the deceased alive on 4-21 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jaime F. Casellas M.D.				23B. DATE SIGNED 4-21-71	
23C. PHYSICIAN'S NAME (Type) JAIME F. CASELLAS M.D.		23D. ADDRESS UNIVERSITY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-26-71		24C. NAME of CEMETERY or CREMATORY Auburn Mt. Auburn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. APR 28 1971			
25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR ADDRESS Mary-Elizabeth Law 802 Madison Avenue			

240-3 A. 4. 5. 6. 7. 8.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4117	
C-452 71 4117		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Collins, Sharon Denise (Burch)</i>		2. DATE AND HOUR OF DEATH <i>4.23.71 5:45 PM</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>University Hospital</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY _____ C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>3909 Edmondson Ave.</i> <i>2037</i>			
5. SEX <i>♀</i>	6. RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-4-63</i>	9. AGE (In years last birthday) <i>8</i>	If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>School</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>John Collins</i>		14. MOTHER'S MAIDEN NAME <i>Ocie Lee Wall</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Ocie Lee Burch</i> ADDRESS <i>3909 Edmondson Avenue</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>(Meningoencephalitis?)</i> (B) <i>(Meningoencephalitis?)</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5.45 PM</i> <i>1-2 days</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>4.22.71</i> to <i>4.23.71</i> and that (I) (we) last saw the deceased alive on <i>4.23.71</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Yupadee Vorasubhin M.D.</i>		23B. DATE SIGNED <i>4.23.71</i>			
23C. PHYSICIAN'S NAME (Type) <i>YUPADEE VORASUBHIN</i>		23D. ADDRESS <i>University Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>4-27-71</i>	24C. NAME of CEMETERY or CREMATORY <i>Arbutus Memorial Park</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 28 1971</i>		25B. NAME OF REGISTRAR <i>John E. Feltz, Jr.</i>		25C. FUNERAL DIRECTOR <i>Mary-Elizabeth Law</i> ADDRESS <i>802 Madison Avenue</i>	

2-10-17

2-10-17

2

2-10-17

BIRTH NO. _____

1. NAME OF DECEASED (Type or Print) **J. ARTHUR BLAKE**

2. DATE OF DEATH Known ☐ Month Day Year Hour
Estimated ☐ M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
SOUTH BALTO. GENERAL HOSPITAL

3. DATE PRONOUNCED DEAD Month Day Year Hour
April 23, 1971 7:08 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE **Maryland** B. COUNTY **Baltimore**

6. SEX **Male** 7. RACE **White** 8. MARRIED ☒ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN **Riverview** D. INSIDE CITY LIMITS? YES ☐ NO ☐

9. DATE OF BIRTH **8-9-1932** 10. AGE (In years lost birthday) **38** If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER **3137 Birkley Avenue 3049 Freeway** 53-00

11. BIRTHPLACE (State or foreign country) **West Virginia** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13. FATHER'S NAME **Harley Blake**

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Electrician** 14B. KIND OF BUSINESS OR INDUSTRY _____

15. MOTHER'S MAIDEN NAME **Edith (Unknown)**

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **Yes Korean**

17. SOCIAL SECURITY NO. **232-46-4538** 18. INFORMANT ADDRESS **Mrs. Pat Y. Blake, 3049 Freeway 21227**

19. CAUSE OF DEATH **Multiple Injuries** APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: _____

(B) DUE TO, OR AS A CONSEQUENCE OF: _____

(C) _____

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). _____

20A. DATE OF OPERATION _____ 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____ 21. AUTOPSY? (Yes or No) **yes**

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) **Street**

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? **800 Block Patapsco Avenue** 25-34

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) **4-23-71 2:30 A.M.** 22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR? **Driver of car which struck parked trailer truck**

23. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Isidore Mihalakis, M.D.** M.D. CHIEF MEDICAL EXAMINER ☐

EXAMINER'S NAME (Type) **Isidore Mihalakis, M.D.** ASSISTANT MEDICAL EXAMINER ☒ DATE SIGNED **4/23/71**

ASSOCIATE MEDICAL EXAMINER ☐

24A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **4-26-1971** 24C. NAME of CEMETERY or CREMATORY **Glen Haven Cemetery** 24D. LOCATION (City, town, or county) (State) **Glen Burnie, Anne Arundel Co., Md.**

25A. DATE REC'D BY HEALTH DEPT. **APR 28 1971** 25B. NAME OF REGISTRAR **Robert E. Taylor, Jr.** 25C. FUNERAL DIRECTOR ADDRESS **Howard H. Hubbard, 4107 Wilkens Ave. 21229**

W. B. [Signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4119	
<div style="display: flex; justify-content: space-between;"> C-456 71 4119 </div>					
1. NAME OF DECEASED (Type or Print) CLEMMER, Cecil R			2. DATE AND HOUR OF DEATH 4-26-71 5:30 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Pennsylvania B. COUNTY Fayette		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218			C. CITY OR TOWN Connellsville		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Male			6. RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) B&O RR			10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 1-21-96
11. BIRTHPLACE (State or foreign country) Smithville, Pa.			9. AGE (In years last birthday) 75		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Everette Clemmer		
14. MOTHER'S MAIDEN NAME Emma Smith			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 17 to 10- 18		
16. SOCIAL SECURITY NO. 705-09-5679			17. INFORMANT ADDRESS VA Hospital Records, Baltimore, Md. 21218		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF:				48 hrs.	
(B) Chronic renal failure DUE TO, OR AS A CONSEQUENCE OF:				4 months.	
(C) Chronic glomerulonephritis				Years.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Net While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that XII (this hospital) attended the deceased from April 24, 19 71 to April 26, 19 71 that II (we) last saw the deceased alive on April 26, 19 71 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (XX) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael B. Troner M.D.				23B. DATE SIGNED 4/27/71	
23C. PHYSICIAN'S NAME (Type) MICHAEL B. TRONER, M.D.				23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 4/30/1971		24C. NAME OF CEMETERY or CREMATORY Green Ridge Mem. Park	
24D. LOCATION (City, town, or county) (State) Connellsville Penna.		25A. DATE REC'D BY HEALTH DEPT. APR 28 1971			
25B. NAME OF REGISTRAR Robert C. Altenburg		25C. FUNERAL DIRECTOR ADDRESS 6009 Harford Rd. - Balto., Md. 21214			

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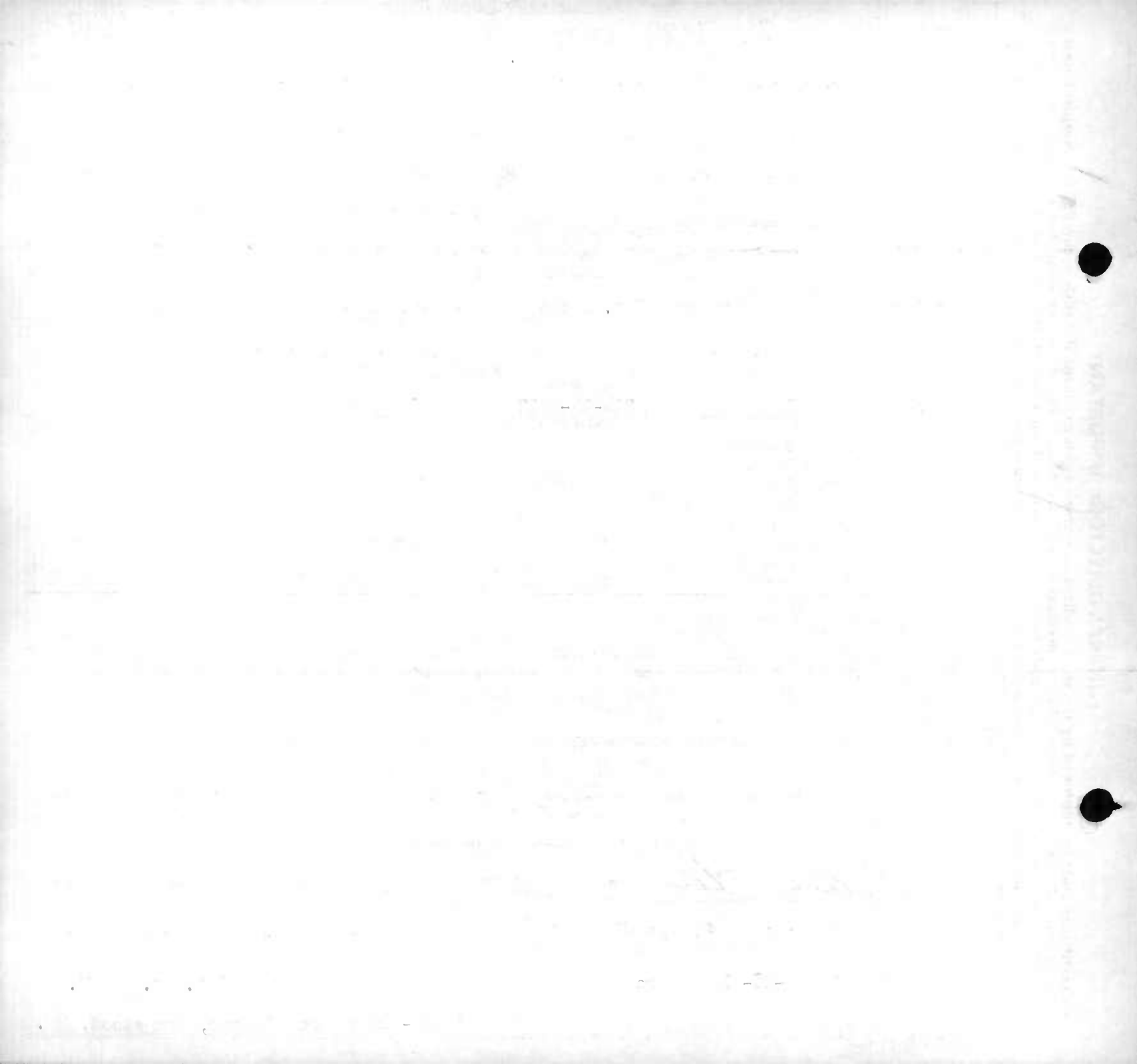
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

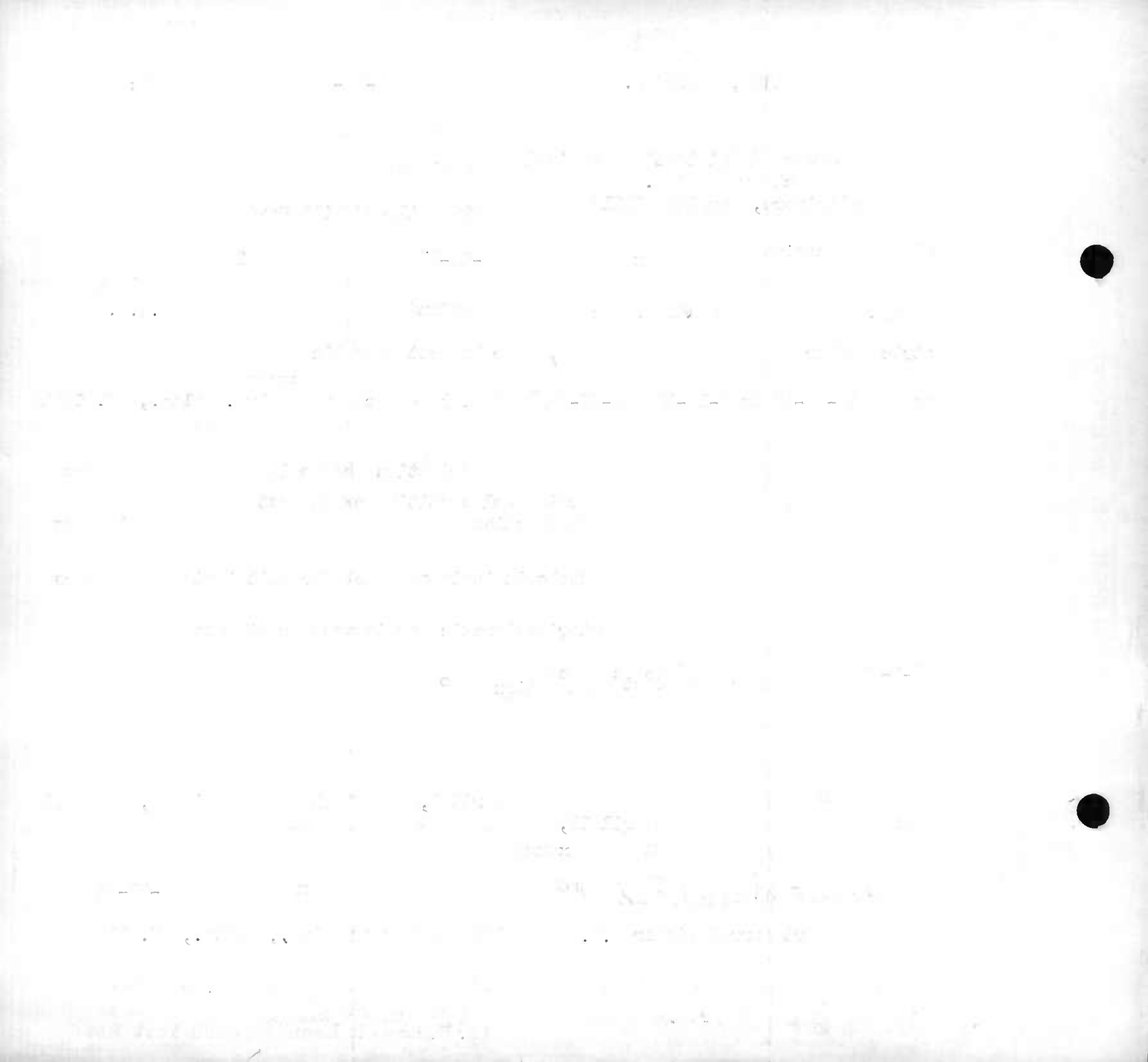
A-652 71 4120		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 4120	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) RAYMOND F. ARMA COST SR.			2. DATE AND HOUR OF DEATH 4-25-71 1:00 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSP.			A. STATE MD. B. COUNTY BALTIMORE		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			C. CITY OR TOWN UPPER CO		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER BLACK ROCK ROAD 5300		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-29-97	9. AGE (In years lost birthday) 73	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Farmer & Ins. Agent			11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JOSEPH ARMA COST			14. MOTHER'S MAIDEN NAME DELLA MARTIN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI			16. SOCIAL SECURITY NO. 214-24-4932		17. INFORMANT MEDICAL RECORD
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ASCVD → MYOCARDIAL INFARCTION → CARDIOGENIC			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 HRS		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: STROKE → ARTERY THROMBOSIS		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) - NO -	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -	
21D. TIME OF INJURY (APPROX.) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -	
22. I certify that (I) (this hospital) attended the deceased from 4-25-71 1971 to 4-25-71 1971 that (I) (we) last saw the deceased alive on 4-25-71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lester A. Reid, M.D.			Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4-25-71
23C. PHYSICIAN'S NAME (Type) LESTER A. REID, M.D.			23D. ADDRESS UNION MEMORIAL HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-28-71		24C. NAME of CEMETERY or CREMATORY Grace Cemetery	
24D. LOCATION Upperco Balto. Co. Md.		25A. DATE REC'D BY HEALTH DEPT. APR 28 1971			
25B. NAME OF REGISTRAR J. J. J. J. J.		25C. FUNERAL DIRECTOR Tipton-Eline Funeral Home, Hampstead, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

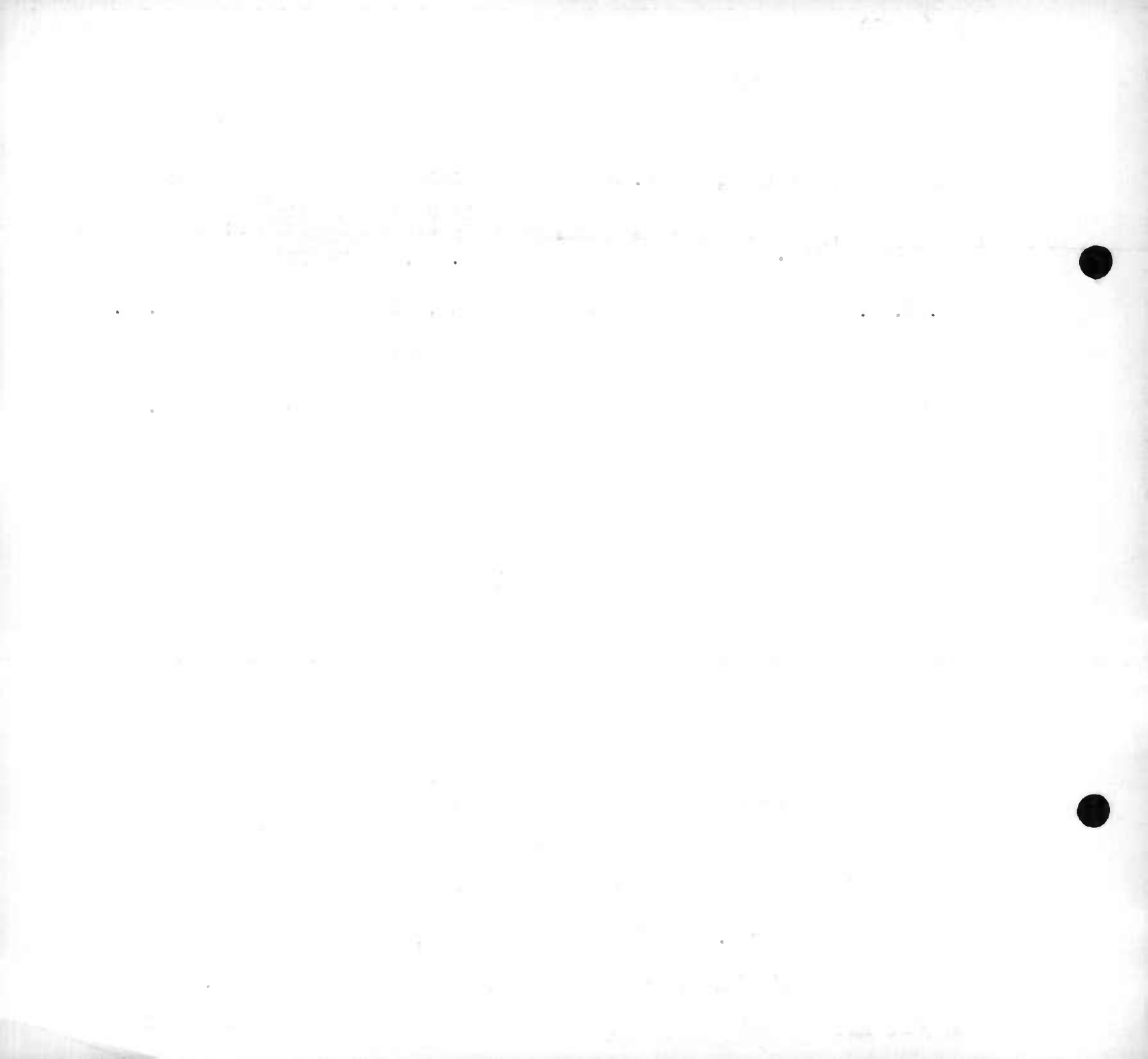
BALTIMORE CITY HEALTH DEPARTMENT				71 4121	
M-260				71 4121	
BIRTH NO.				REG. NO.	
1. NAME OF DECEASED (Type or Print) MEAGHER, MAHER, Edward J.			2. DATE AND HOUR OF DEATH 4-22-71 4:00 P		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Veterans Administration Hospital 3900 Loch Raven Blvd. Baltimore, Maryland 21218			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore		
5. SEX Male			6. RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 9-18-88			9. AGE (In years last birthday) 82		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Superintendent			10B. KIND OF BUSINESS OR INDUSTRY Civil Service		11. BIRTHPLACE (State or foreign country) Ireland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Patrick Maher		
14. MOTHER'S MAIDEN NAME Magaret Coughlin			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 10-16-17 to 8-19-19		
16. SOCIAL SECURITY NO. 216-07-9254			17. INFORMANT Records ADDRESS VAH, 3900 Loch Raven Blvd. Balto., Md. 21218		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Aspiration Pneumonia (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Acute Cholecystitis Common duct Obstruction Cholelithiasis and Choledocholithiasis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 Days 3 Weeks Years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Arteriosclerotic Cardiovascular disease					
19A. DATE OF OPERATION 4-2-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cholecystectomy and common duct exploration		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from April 2, 1971 to April 22, 1971 that (U) (we) last saw the deceased alive on April 22, 1971 and that in (O) (our) opinion death occurred on the date and hour and from the causes stated above, (U) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert Darryl Fisher M.D.			23B. DATE SIGNED 4-23-71		23C. PHYSICIAN'S NAME (Type) Robert Darryl Fisher M.D.
23D. ADDRESS 3900 Loch Raven Blvd., Balto., Md. 21218					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 26 APR 71		24C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery	
24D. LOCATION Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. APR 28 1971		25B. NAME of REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR J. E. Lowell Lemmon	
25D. ADDRESS 6500 York Road					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

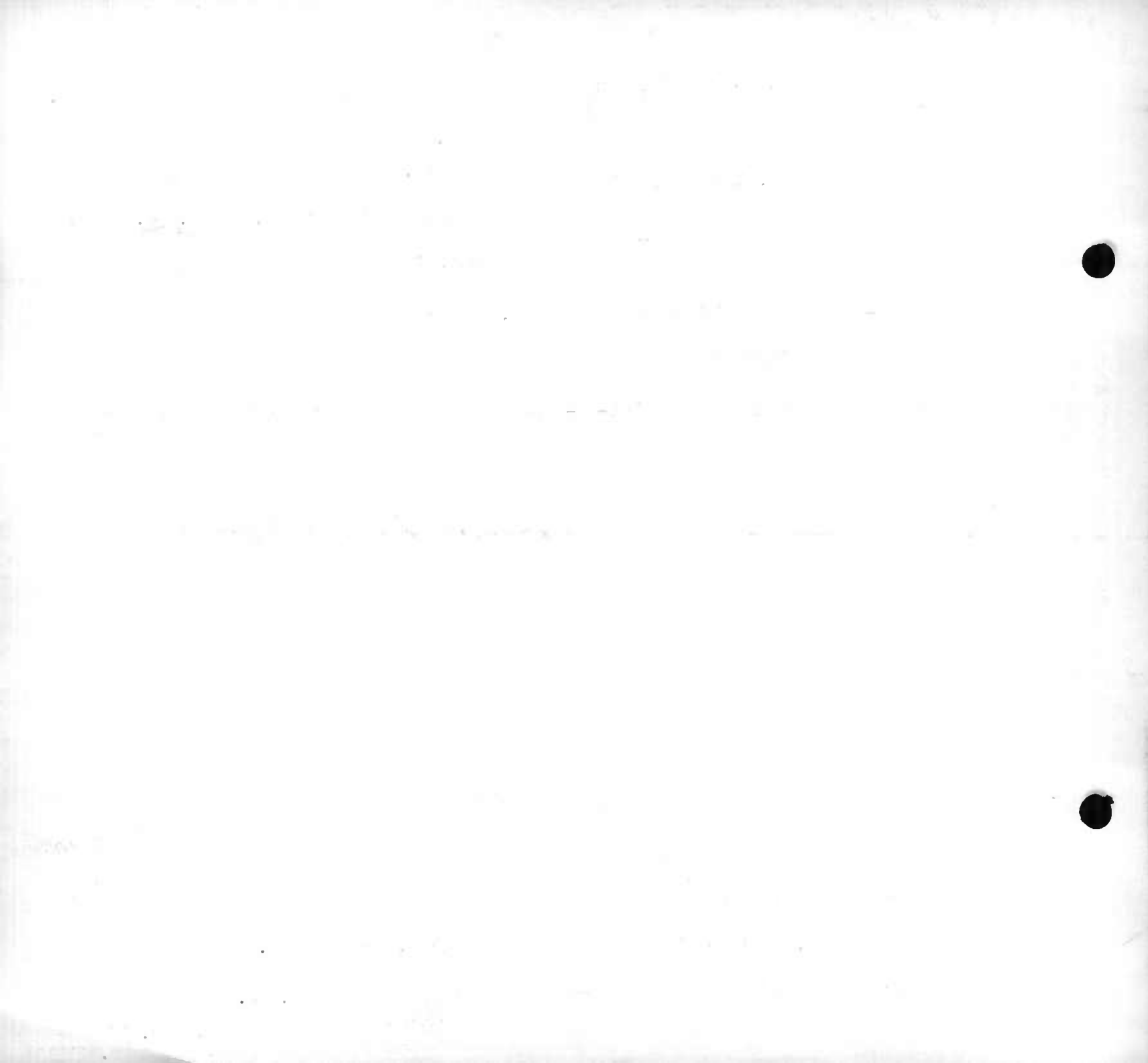
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4122	
C-650 71 4122		BIRTH NO.		71 4122	
1. NAME OF DECEASED (Type or Print) LYNCH J. CURRIN		2. DATE AND HOUR OF DEATH 4/20/71 8 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION MD General Hospital, Balto. MD		A. STATE MD		B. COUNTY Baltimore City	
5. SEX Male		6. RACE Cauc.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Feb. 24, 1899		9. AGE (In years last birthday) 72		10. UNDER 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) C. P. A.		10B. KIND OF BUSINESS OR INDUSTRY Accountant		11. BIRTHPLACE (State or foreign country) Balto, City	
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME George Waddy Currin		14. MOTHER'S MAIDEN NAME Katherine Sharky Currin	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no		17. INFORMANT Katherine Woodrow Currin Balto. MD	
18. 395.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac Arrest (B) DUE TO, OR AS A CONSEQUENCE OF: Pneumonia & Heart Dis (C) DUE TO, OR AS A CONSEQUENCE OF: Corticosteroids Pulmonary & Renal		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs 60 yrs 10 yrs 2 wks	
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1969 to 4/20/71 that (I) (we) last saw the deceased alive on 4/20/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Walter E. Koeleim M.D.		23B. PHYSICIAN'S NAME (Type) Walter E. Koeleim		23C. DATE SIGNED 4/20/71	
23D. ADDRESS Balto, City MD		23E. PHYSICIAN'S DEGREE M.D.		23F. ADDRESS LeCompte Funeral Home Cambridge MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/24/71		24C. NAME OF CEMETERY or CREMATORY Cambridge Cemetery	
24D. LOCATION Cambridge Dor.		24E. LOCATION MD		24F. LOCATION MD	
25A. DATE REC'D BY HEALTH DEPT. APR 29 1971		25B. NAME OF REGISTRAR J. E. E. E. E. E.		25C. FUNERAL DIRECTOR LeCompte Funeral Home Cambridge MD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4123	
BIRTH NO. 71 4123		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Coleman Bridgeman		2. DATE AND HOUR OF DEATH 4/21/71 5 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Balto. City Hospital		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE Md. B. COUNTY 2634			
		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1052 Armistead Way, Balto. Md. 21205			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/21/23	9. AGE (in years last birthday) 48
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) handy-man		10B. KIND OF BUSINESS OR INDUSTRY Ackerman & Baynes Co.		11. BIRTHPLACE (State or foreign country) Kentucky	
13. FATHER'S NAME Lee Bridgeman		14. MOTHER'S MAIDEN NAME Anna Johnson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW II		16. SOCIAL SECURITY NO. 406-14-7136		17. INFORMANT Delphia Bridgeman (wife)	
				ADDRESS same address	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 410.9 I		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary Thrombosis (B) Coronary Heart Disease DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (necify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1965 19 3/20/71 to 19 that (I) (we) last saw the deceased alive on 3/20/71 19 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. - Taken City Hosp.					
23A. SIGNATURE Louis Vogel		23B. DATE SIGNED 4/23/71			
23C. PHYSICIAN'S NAME (Type) Dr. Louis Vogel		23D. ADDRESS 2601 E. Monument St.			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 4/24/71		24C. NAME of CEMETERY or CREMATORY Gardens of Faith Cemetery	
				24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 29 1971		25B. NAME OF REGISTRAR John E. Taylor, M.D.		25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto Md. 21213	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

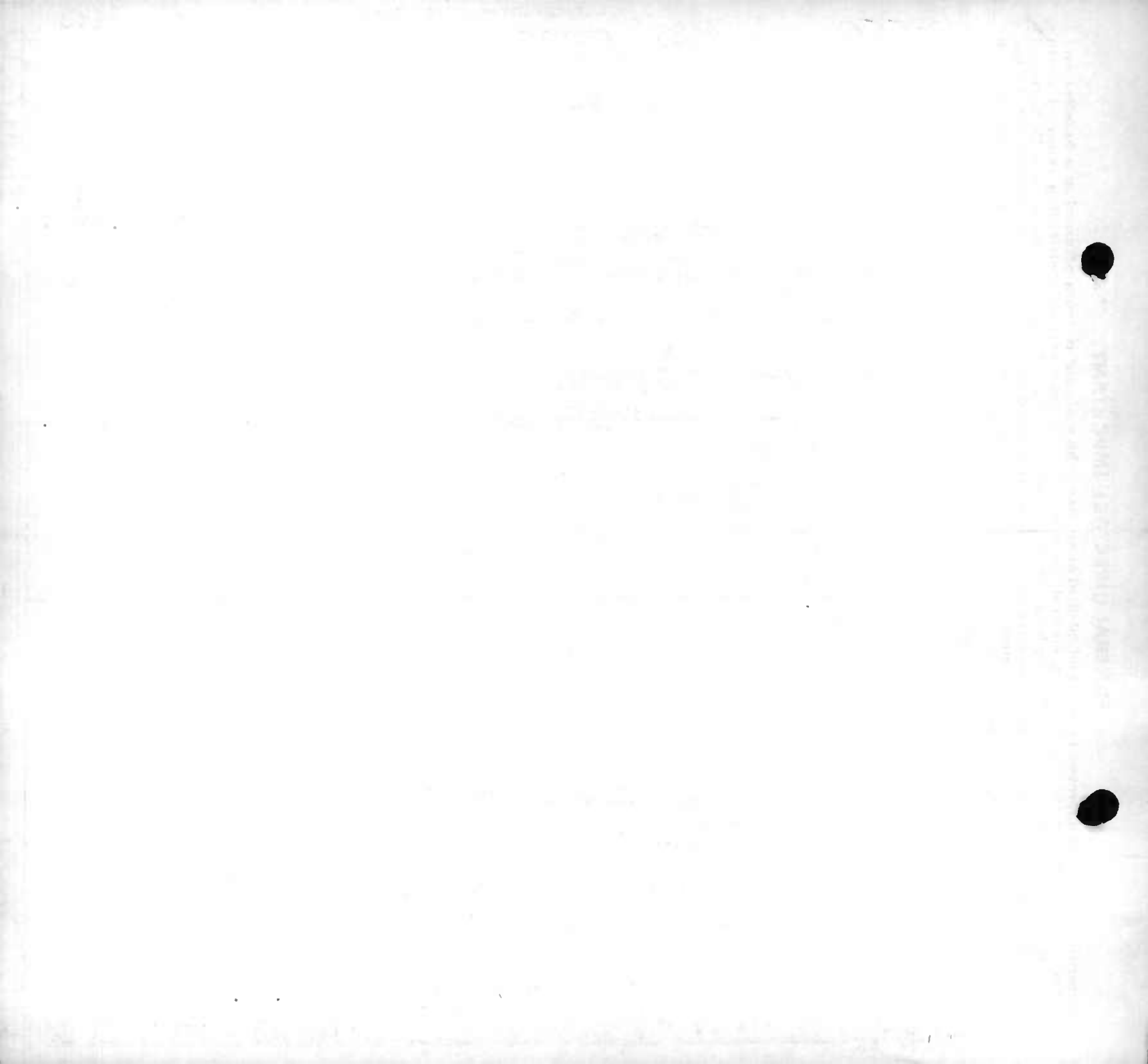
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) Joseph Duschell		2. DATE AND HOUR OF DEATH April 23, 1971 7:05 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 48 Maryland General Hospt. Baltimore, Md. 21201		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 841			
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 2932 Edison Highway			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-2-05	9. AGE (In years last birthday) 65
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) foreman		10B. KIND OF BUSINESS OR INDUSTRY Armco Steel		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Louis Duschel		14. MOTHER'S MAIDEN NAME Mary Drexler			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-05-7664		17. INFORMANT Marie Duschel (wife)	
				ADDRESS 2932 Edison Hwy	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 486.91 + 250.9		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Renal failure (B) Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF: CVA (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 4 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetes Mellitus			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/15 19 71 to 4/23 19 71 that (I) (we) last saw the deceased alive on 4/23 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Victor R. Felipa M.D.		23B. DATE SIGNED 4/23/71			
23C. PHYSICIAN'S NAME (Type) Victor R. Felipa		23D. ADDRESS Maryland General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 4/27/71		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	
				24D. LOCATION (City, town, or county) State Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 29 1971		25B. NAME OF REGISTRAR Rose E. Jaber, M.D.		25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc.	
				ADDRESS 3331 Brehms	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-550 71 4125				BALTIMORE CITY HEALTH DEPARTMENT		71 4125	
BIRTH NO.				CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) LAMAHAN LAWRENCE				2. DATE AND HOUR OF DEATH 4-26-71 3:05pm M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MARYLAND		B. COUNTY 2642	
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 33rd and CALVERT		4702 Shamrock Ave. Balto Md. 21206	
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-11-04	9. AGE (in years last birthday) 66	10. Under 1 Yr. 11. Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEEL COMPANY AS A DRIVER				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) IRELAND	
12. CITIZEN OF WHAT COUNTRY? AMERICAN				13. FATHER'S NAME HENRY LAMAHAN			
14. MOTHER'S MAIDEN NAME MARY KIGGINS				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. 212-01-9160				17. INFORMANT MARY LAMAHAN ADDRESS 4702 Shamrock Ave.			
18. 4-12-71 CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE RESPIRATORY INSUFFICIENCY DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) CHRONIC LUNG DISEASE - DUE TO, OR AS A CONSEQUENCE OF:			
				(C) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). CHRONIC RENAL DISEASE							
19A. DATE OF OPERATION 4-26-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ADRENAL INSUFFICIENCY		20A. AUTOPSY (Yes or No) —		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) —		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? — (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —			
22. I certify that (I) (this hospital) attended the deceased from 4-18-71 to 4-26-71 19 71 that (I) (we) last saw the deceased alive on 4-26-71 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (dtd) (did not) view the body after death.							
23A. SIGNATURE Juan M. Calderon				23B. DATE SIGNED 4-26-71		23C. PHYSICIAN'S NAME (Type) JUAN M. CALDERON V.	
23D. ADDRESS —				23E. DEGREE —			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 4/28/71		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 29 1971		25B. NAME OF REGISTRAR —		25C. FUNERAL DIRECTOR —		ADDRESS —	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-432 4126				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 4126	
MARGARET C. FOLTZ-DIORIO CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) FOLTZ-DIORIO MARGARET				2. DATE AND HOUR OF DEATH 4-26-71 2:55 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Montebello State Hosp.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALT. C. CITY OR TOWN RANDALLSTOWN D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 3709 STONYBROOK RD.			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-12-87	9. AGE (In years last birthday) 83	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George Clark			14. MOTHER'S MAIDEN NAME Margaret Dempsey				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 219-20-8900		17. INFORMANT ADDRESS MRS TERESA SALEMI 3709 STONYBROOK RD		
18. 4337 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Possible CVA? (B) Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF: (C) Generalized Arteriosclerosis left middle cerebral thrombosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 1/2 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). pt. Hemiparesis secondary to							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Dec. 18 1967 to April 26 1971 , that (I) (we) lost saw the deceased alive on April 26 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Corazon M. Cuevas, M.D.				23B. DATE SIGNED 4-26-71			
23C. PHYSICIAN'S NAME (Type) CORAZON M. CUEVAS, M.D.				23D. ADDRESS Montebello State Hosp.			
24A. BURIAL CREMATION REMOVAL (Specify) BURIAL		24B. DATE 4-30-71		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer		24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.	
25A. DATE REC'D BY HEALTH DEPT. APR 29 1971				25C. FUNERAL DIRECTOR ADDRESS LEONARD J. RUCK, INC BALTO, MD.			

10-15-21

10-15-21

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R-263

71

4127

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71

4127

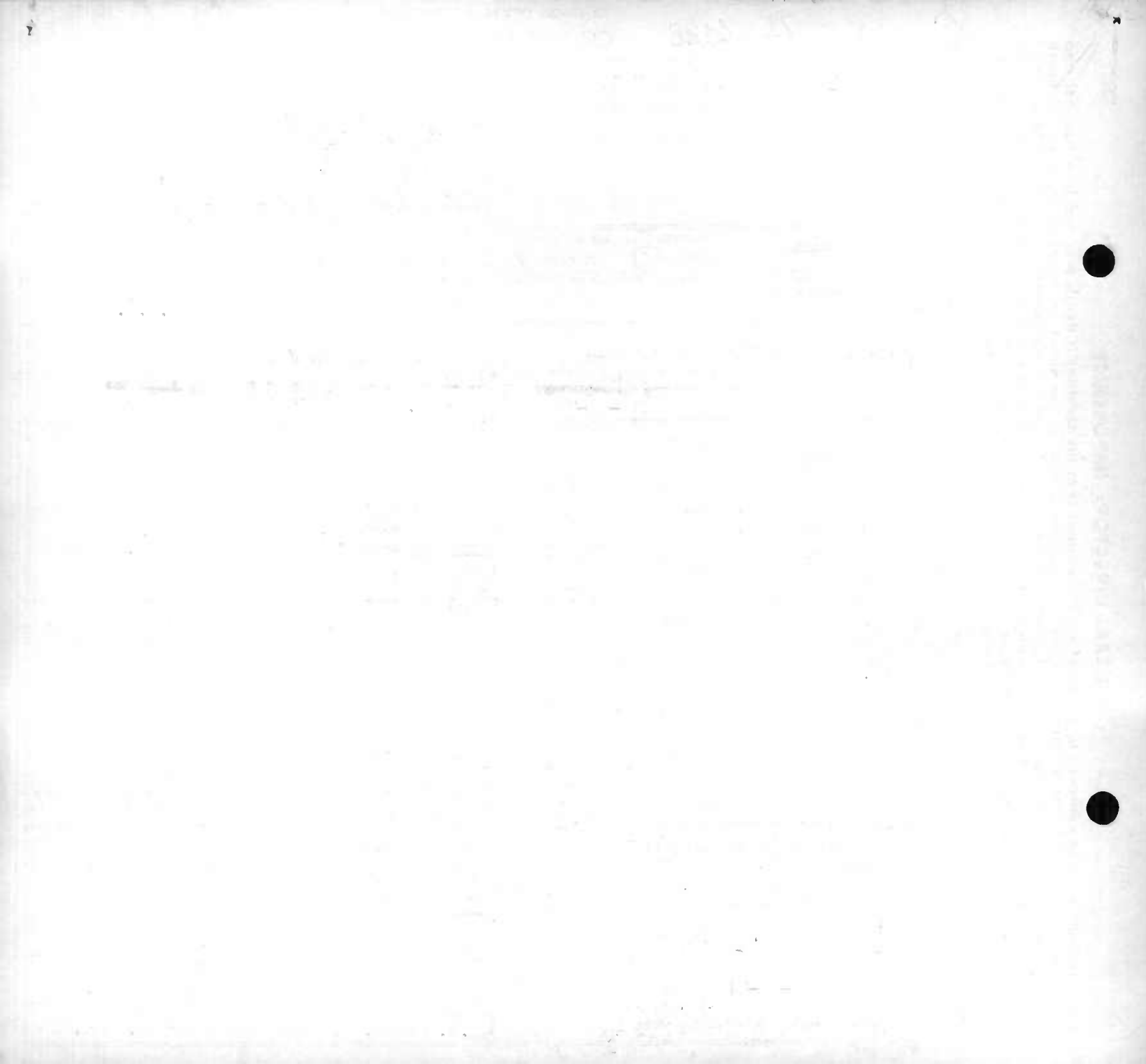
BIRTH NO.

1. NAME OF DECEASED (Type or Print) Philip Louis Rueckert		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour April 26, 1971 8:00 P.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Oct. 6, '98		10. AGE (In years last birthday) 72	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 219-10-1743	
13. FATHER'S NAME George Frederick Rueckert		15. MOTHER'S MAIDEN NAME Rosa List	
18. INFORMANT Mrs. Bertha W. Rueckert Same		ADDRESS	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/1/71	
24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 29 1971		25B. NAME OF REGISTRAR Leonard J. Ruck Inc.	
25C. FUNERAL DIRECTOR 5305 Harford Rd.		ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

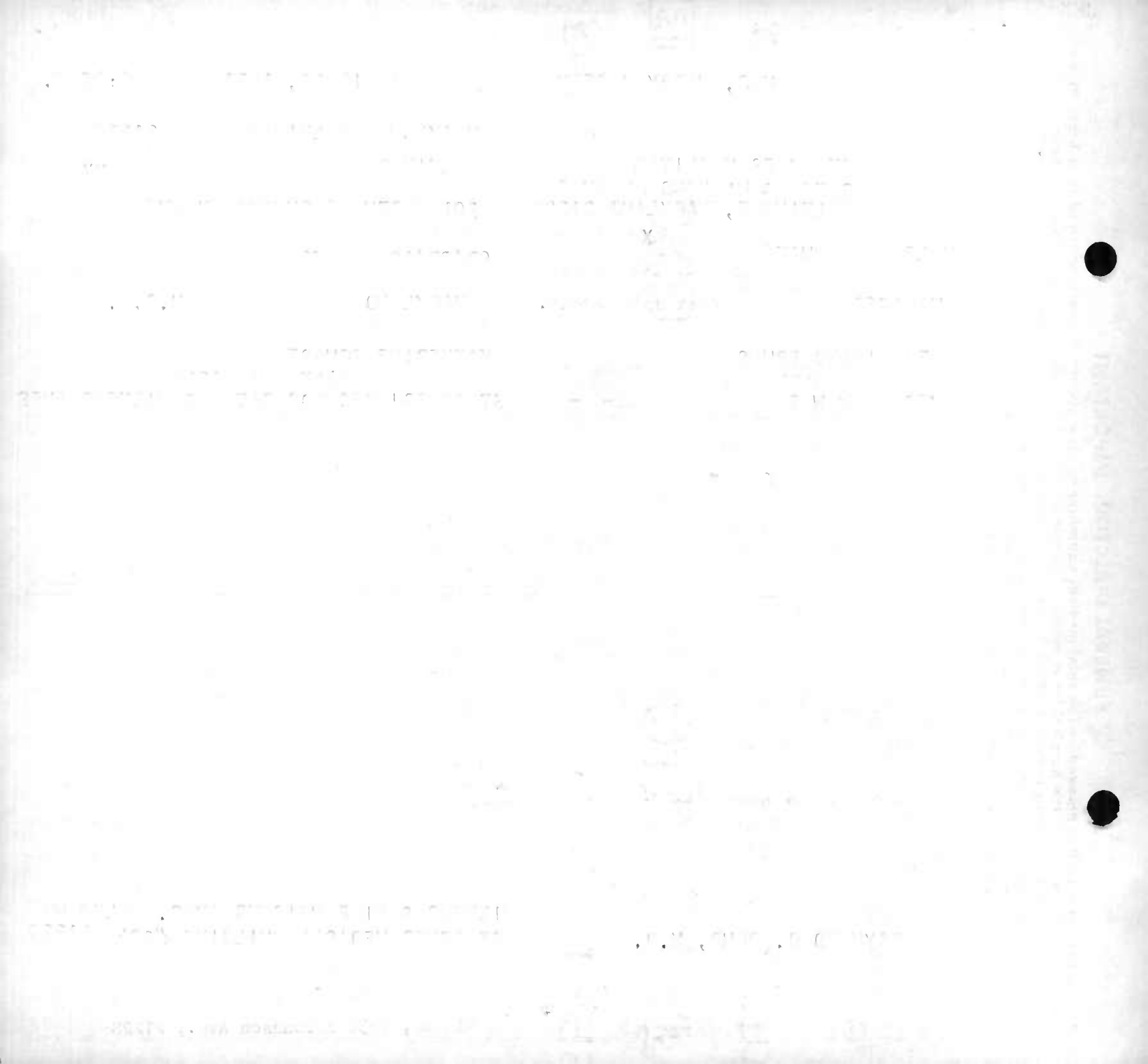
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
C-630 71 4128		71 4128		71 4128	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) NAOMI CATHERINE JOHNSON CROWDY		2. DATE AND HOUR OF DEATH 4-26-71-12⁴⁵ AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 5200			
FULL NAME OF HOSPITAL OR INSTITUTION 33 JOHN HOPKINS		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Annapolis D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female		6. RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH 7-15-27		9. AGE (in years last birthday) 43		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bar Maid	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.		13. FATHER'S NAME Hilton McKinley Johnson	
14. MOTHER'S MAIDEN NAME Mary Catherine Johnson		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-26-7587	
17. INFORMANT Mary C. Johnson Rt 5 Box 80 Anna, Md		ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Uremia		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Recurrent Carcinoma of Cervix		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION N/A		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/15 19 71 to 4/26 19 71 that (I) (we) last saw the deceased alive on 4/25 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE John F. Rampone, MD		23B. DATE SIGNED 4/26/71		23C. PHYSICIAN'S NAME (Type) John F. Rampone, MD	
23D. ADDRESS The Johns Hopkins Hosp		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 4-29-71		24C. NAME OF CEMETERY OR CREMATORY Asbury Broadneck		24D. LOCATION (City, town, or county) (State) Anne Arundel Co, Md	
25A. DATE REC'D BY HEALTH DEPT. APR 29 1971		25B. NAME OF REGISTRAR John F. Rampone, MD		25C. FUNERAL DIRECTOR C. E. Hicks, 711 1922 Forest Drive, Anna, Md	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4129	
BIRTH NO. B-652		71 4129		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) BRUNS, HARRY JOSEPH			2. DATE AND HOUR OF DEATH APRIL 27, 1971 6:45 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229			A. STATE MARYLAND B. COUNTY BALTIMORE		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER 301 NORTH BEACHWOOD AVENUE					
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 07/07/19	9. AGE (In years last birthday) 51	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANAGER		10B. KIND OF BUSINESS OR INDUSTRY Steamship Repres.		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME FERDINAND BRUNS			14. MOTHER'S MAIDEN NAME KATHERINE SCHARF		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service YES W W 2			16. SOCIAL SECURITY NO. 213-05-8025		
17. INFORMANT BALTO MD 21229			ADDRESS ST AGNES' RECORDS CATON & WILKENS AVES		
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiogenic Shock			2 hr.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
			(B) Acute Myocardial Infarction 1 day		
			(C) ASCVB Years		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 4/27 19 71 to 4/27 19 71 that (1) (we) last saw the deceased alive on 4/27 19 71 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Raymond D. Bahr			23B. DATE SIGNED 4/27/71		
23C. PHYSICIAN'S NAME (Type) RAYMOND D. BAHR, M.D.			23D. ADDRESS WILKENS & PINE HEIGHTS AVES. BALTO MD ST AGNES MEDICAL BUILDING #304 21229		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/30/71		24C. NAME of CEMETERY or CREMATORY Crestlawn Cemetery	
24D. LOCATION Marriottsville		24E. (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. APR 29 1971		25B. NAME OF REGISTRAR John E. Taber, M.D.		25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Ave., 21228	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4130	
CERTIFICATE OF DEATH					
BIRTH NO. S-315 71 4130		1. NAME OF DECEASED <small>(Type or Print)</small> SHIRLEY STEPHENSON			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION University Hospital 38		2. DATE AND HOUR OF DEATH 26 April 1971 5:20 AM 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY 1801 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 869 W. Lexington St.			
5. SEX F	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-24-51	9. AGE (In years last birthday) 20	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N. C.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME June Collins			
14. MOTHER'S MAIDEN NAME Corene		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown			
16. SOCIAL SECURITY NO.		17. INFORMANT Rev Henry Syephenson, Same ADDRESS			
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <small>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</small> ANTECEDENT CAUSES <small>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</small> </div> <div style="width: 15%; text-align: center;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH </div> </div>					
<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> (A) IMMEDIATE CAUSE Peritonitis DUE TO, OR AS A CONSEQUENCE OF: (B) Small bowel perforation. DUE TO, OR AS A CONSEQUENCE OF: Surgery for tubal-ovarian abscess (C) </div> <div style="width: 15%;"></div> </div>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). None.					
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION 3-24-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Tubal-ovarian abscess		20A. AUTOPSY? (Yes or No) ?	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input checked="" type="checkbox"/> NO			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 3-22 19 71 to 4-26 19 71 that (X) (we) last saw the deceased alive on 4-26 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael P. Buchness MD		23B. DATE SIGNED 4-26-71		23C. PHYSICIAN'S NAME (Type) MICHAEL P. BUCHNESS MD.	
23D. ADDRESS University Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 6/2/71		24C. NAME OF CEMETERY OR CREMATORY Southern Pines		24D. LOCATION (City, town, or county) (State) North Carolina	
25A. DATE REC'D BY HEALTH DEPT. APR 29 1971		25B. NAME OF REGISTRAR Rae E. T. x2		25C. FUNERAL DIRECTOR Adolphus Halstead 1206 W ADDRESS orth A e	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO.		71 4131		CERTIFICATE OF DEATH		REG. NO. 71 4131	
1. NAME OF DECEASED (Type or Print) JULIUS THOMPSON						2. DATE AND HOUR OF DEATH 4/27/1971 10:30 P M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 The Johns Hopkins Hospital						4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE Maryland B. COUNTY 1510 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4008 Springdale Avenue					
5. SEX Male		6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/11/06		9. AGE (In years last birthday) 65		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer				11. BIRTHPLACE (State or foreign country) Anderson, S. C.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Ben Thompson						14. MOTHER'S MAIDEN NAME Carrie Warsley					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 250-18-1704		17. INFORMANT Lila Thompson 4008 Springdale Avenue					
18. 03519 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) SEPSIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CVA'S, CARDIAC PACEMAKER						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
						(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
						(B) DUE TO, OR AS A CONSEQUENCE OF:					
19. DATE OF OPERATION						19A. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from 3/18 19 71 to 4/27 19 71 that (H) (we) last saw the deceased alive on 4/27 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Trexler M Topping MD						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4/27/71			
23C. PHYSICIAN'S NAME (Type) TREXLER M TOPPING MD						23D. ADDRESS The Johns Hopkins Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-1-71		24C. NAME OF CEMETERY OR CREMATORY Carver Memorial Park				24D. LOCATION (City, town, or county) (State) Laurel, Maryland			
25A. DATE REC'D BY HEALTH DEPT. APR 29 1971				25B. NAME OF REGISTRAR Robert E. Taylor, MD.		25C. FUNERAL DIRECTOR Morton & Dyett F. H/1701 H.				ADDRESS 21217 Laurens Street	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-525		1 4132		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 4132	
BIRTH NO. [REDACTED] 1 4132				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JOHNSON ARTHUR				2. DATE AND HOUR OF DEATH 4/28/71 11:30 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 1602			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 Lakeran Hosp. of Maryland 730 ASHBURTON St. Balto. 21216				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 645 N. Calhoun Street			
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 1-4-32	9. AGE (In years last birthday) 39	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bar tender				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Clarence Johnson			
14. MOTHER'S MAIDEN NAME Lovella Johnson				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) —			
16. SOCIAL SECURITY NO. 250-385014				17. INFORMANT Clarence Johnson - 254 Quantico			
18. CAUSE OF DEATH 4369 I				DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebro Vascular Accident			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Accident			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month 17 days			
19A. DATE OF OPERATION 2 - NO -		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NO		20A. AUTOPSY? (Yes) or No? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) —		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3-11-71 to 4-28-71 that (I) (we) last saw the deceased alive on 4-28-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Gakuba				23B. DATE SIGNED 4-28-71		23C. PHYSICIAN'S NAME (Type) C. Gakuba	
23D. ADDRESS 730, ASHBURTON St. Baltimore, Md. 21216				23E. FUNERAL DIRECTOR Morton Dyett F. H. 1701-LAURENS ST.		23F. ADDRESS 21217	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-1-71		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 29 1971		25B. NAME OF REGISTRAR Robert E. Taylor, JR.		25C. FUNERAL DIRECTOR Morton Dyett F. H. 1701-LAURENS ST.		25D. ADDRESS 21217	

Distance between localities of the same species

Distance between localities of the same species

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 4183</u>	
<p><u>M-240</u> BIRTH NO.</p> <p>1. NAME OF DECEASED (Type or Print) <u>Della M. Mickie</u></p>		<p><u>71 4183</u> CERTIFICATE OF DEATH</p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p><u>The Johns Hopkins Hospital</u></p>		<p>2. DATE AND HOUR OF DEATH <u>4/28/71 1:40 a.m.</u></p> <p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1506</u></p> <p>C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>3000 Westwood Avenue</u></p>			
<p>5. SEX <u>Female</u></p> <p>6. RACE <u>Negro</u></p> <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p> <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u></p>		<p>8. DATE OF BIRTH <u>7/29/98</u></p> <p>9. AGE (In years last birthday) <u>72</u></p> <p>11. BIRTHPLACE (State or foreign country) <u>Camden, South Carolina</u></p> <p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>			
<p>13. FATHER'S NAME <u>Allen Izzard</u></p> <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>Maranda Anthony</u></p> <p>16. SOCIAL SECURITY NO. <u>218-18-9754</u></p> <p>17. INFORMANT <u>Mr. Thomas B. Mickie</u> ADDRESS <u>3114 Presstman St. 21216</u></p>			
<p>18. <u>038.81</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p style="text-align: center;"><u>II</u></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>		<p>CAUSE OF DEATH</p> <p>(A) IMMEDIATE CAUSE <u>Uremia</u> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) <u>Klebsiella bacterium</u> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Two week</u> <u>Two week</u></p>	
<p>19A. DATE OF OPERATION <u>0</u></p> <p>21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)</p> <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> <p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>20A. AUTOPSY? (Yes or No) <u>NO</u></p> <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p> <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> <p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (1) (this hospital) attended the deceased from <u>4/1/71</u> 19 <u>71</u> to <u>4/28</u> 19 <u>71</u> that (1) (we) last saw the deceased alive on <u>4/28</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE <u>Michael A. Moore MD</u></p> <p>23C. PHYSICIAN'S NAME (Type) <u>Michael A. Moore MD</u></p>		<p>Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/></p> <p>23D. ADDRESS <u>Johns Hopkins Hospital</u></p>		<p>23B. DATE SIGNED <u>4/28/71</u></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u></p> <p>24B. DATE <u>5-1-71</u></p>		<p>24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u></p> <p>24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u></p>		<p>25A. DATE REC'D BY HEALTH DEPT. <u>APR 29 1971</u></p> <p>25B. NAME OF REGISTRAR <u>Robert E. [unclear]</u></p> <p>25C. FUNERAL DIRECTOR <u>1735 Harford Ave. 81213</u> <u>Marshall W. Jones, Jr.</u></p>	

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VICTOR

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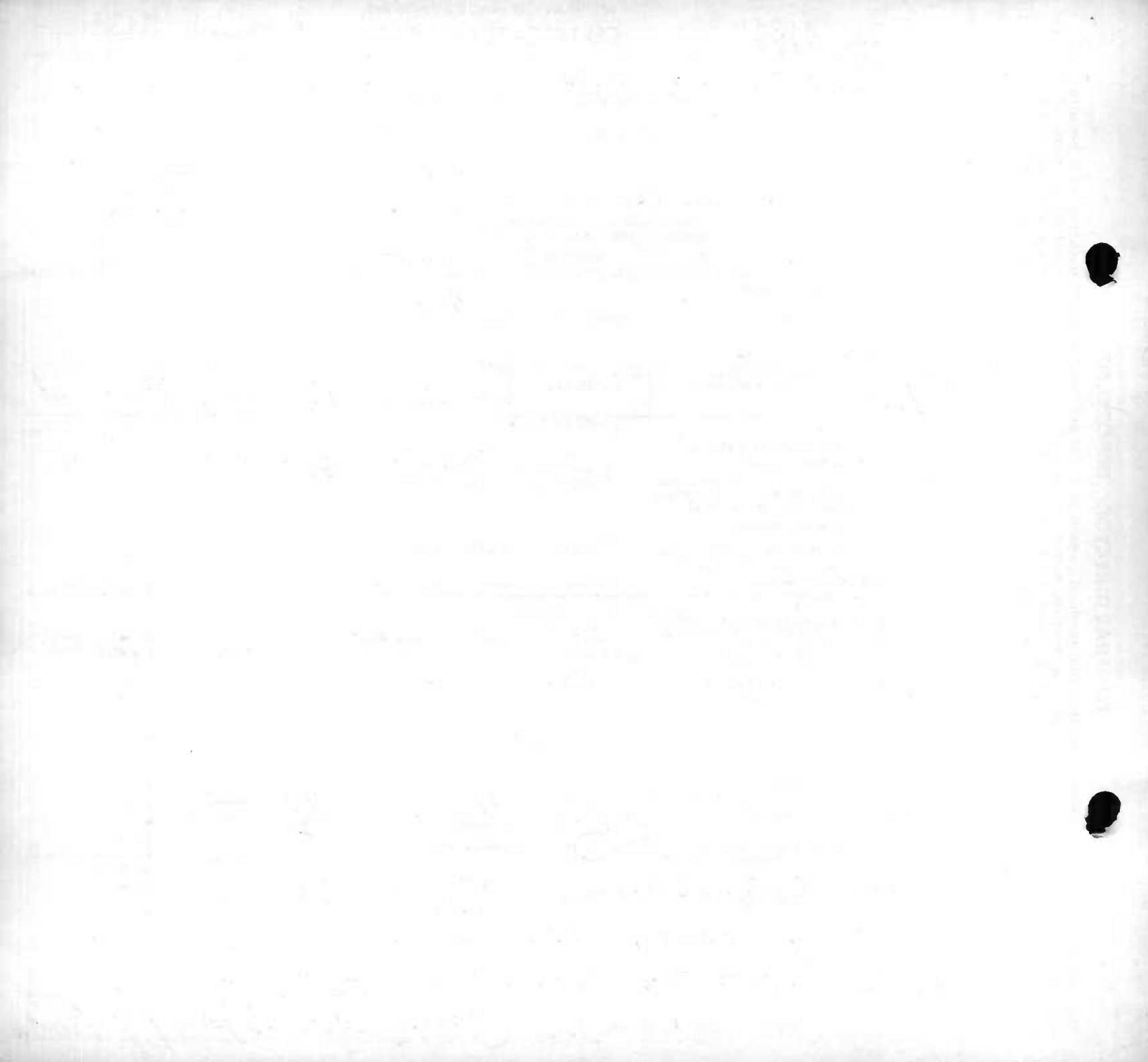
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 71 4134 ✓

BIRTH NO. <u>71 4134</u> <u>69-17073</u>		1. NAME OF DECEASED (Type or Print) <u>Christopher Pate</u>		2. DATE AND HOUR OF DEATH <u>4/28/71</u> <u>12¹⁵</u> <u>A</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 The Johns Hopkins Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>909</u>	
				C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1706 N. Holbrook Street</u>	
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>9/8/69</u>	9. AGE (In years last birthday) <u>1 1/2</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md</u>
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME <u>Robert Pate</u>		
14. MOTHER'S MAIDEN NAME <u>Geraldine Veney</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO.			17. INFORMANT <u>Geraldine Pate</u> ADDRESS <u>1706 Holbrook St</u>		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Metastatic Neuroblastoma</u>					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>4 months</u>					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) _____					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2/14/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>metastatic neuroblastoma</u>		20A. AUTOPSY? (Yes or No) <u>yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) <u>this hospital</u> attended the deceased from <u>1/10</u> 19 <u>71</u> to <u>4/28</u> 19 <u>71</u> that (2) <u>we</u> last saw the deceased alive on <u>4/28</u> 19 <u>71</u> and that (3) <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (4) <u>We</u> (did) (did not) view the body after death.					
23A. SIGNATURE <u>Alan E. Zuckerman</u> DEGREE				23B. DATE SIGNED <u>4/28/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Alan E. Zuckerman, M.D.</u>				23D. ADDRESS <u>The Johns Hopkins Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/30/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>	
24D. LOCATION <u>Balti. Md.</u>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 29 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Joseph J. Rock</u> ADDRESS <u>1307th - Rock</u>	



C-160		71 4135		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		71 4135	
BIRTH NO.		REG. NO.							
1. NAME OF DECEASED (Type or Print)				2. DATE OF DEATH		Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year Hour	
WILLIE COOPER									
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				3. DATE PRONOUNCED DEAD		Month Day Year Hour			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4		21		1971 7:32a	
33 Johns Hopkins Hospital									
6. SEX		7. RACE		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
male		negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years lost birth day)		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER			
March 16, 1928		43				1709 Hartford Ave.			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OR WHAT COUNTRY?		13. FATHER'S NAME			
N. Carolina				U.S.A.		Salisbury Cooper			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME			
Unemployed - Laborer						Pennie Williams			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS	
NO				242-40-8090		Georgianna Christian		922 N. Washington St.	
19. 532.014571.0				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				Upper gastro-intestinal hemorrhage					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE					
				DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES				(B) duodenal ulcer					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				DUE TO, OR AS A CONSEQUENCE OF:					
				(C)					
II				Fatty liver; chronic alcoholism; chronic pancreatitis					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No)	
2								yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23.				I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED	
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					
Isidore Mihalakis, M.D.				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				4/21/71	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Removal		4-22-71				Littleton, N. Carolina			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
APR 29 1971		John E. Taylor, M.D.		Elliott Funeral Home		1129 N. Carolina			

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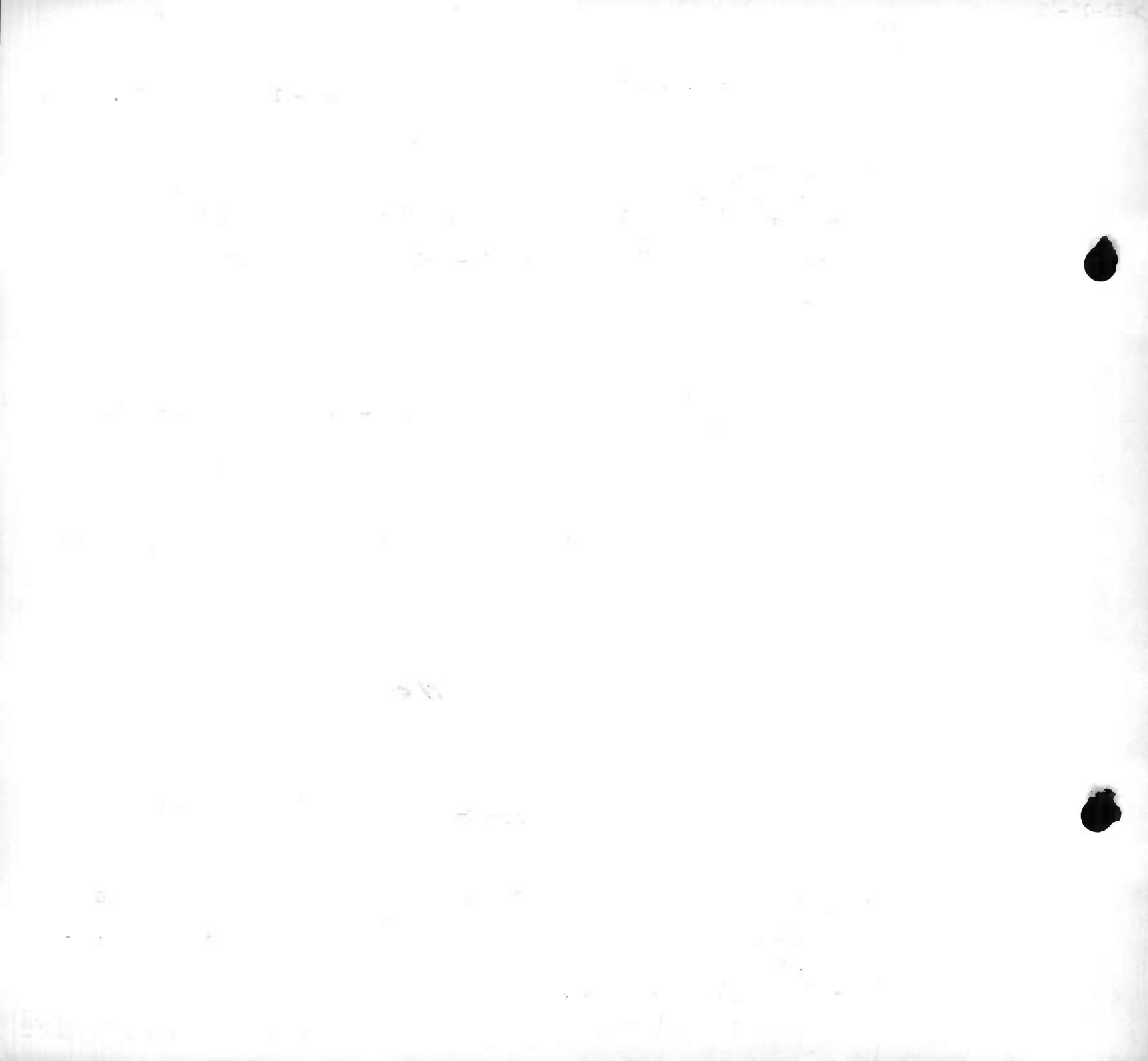
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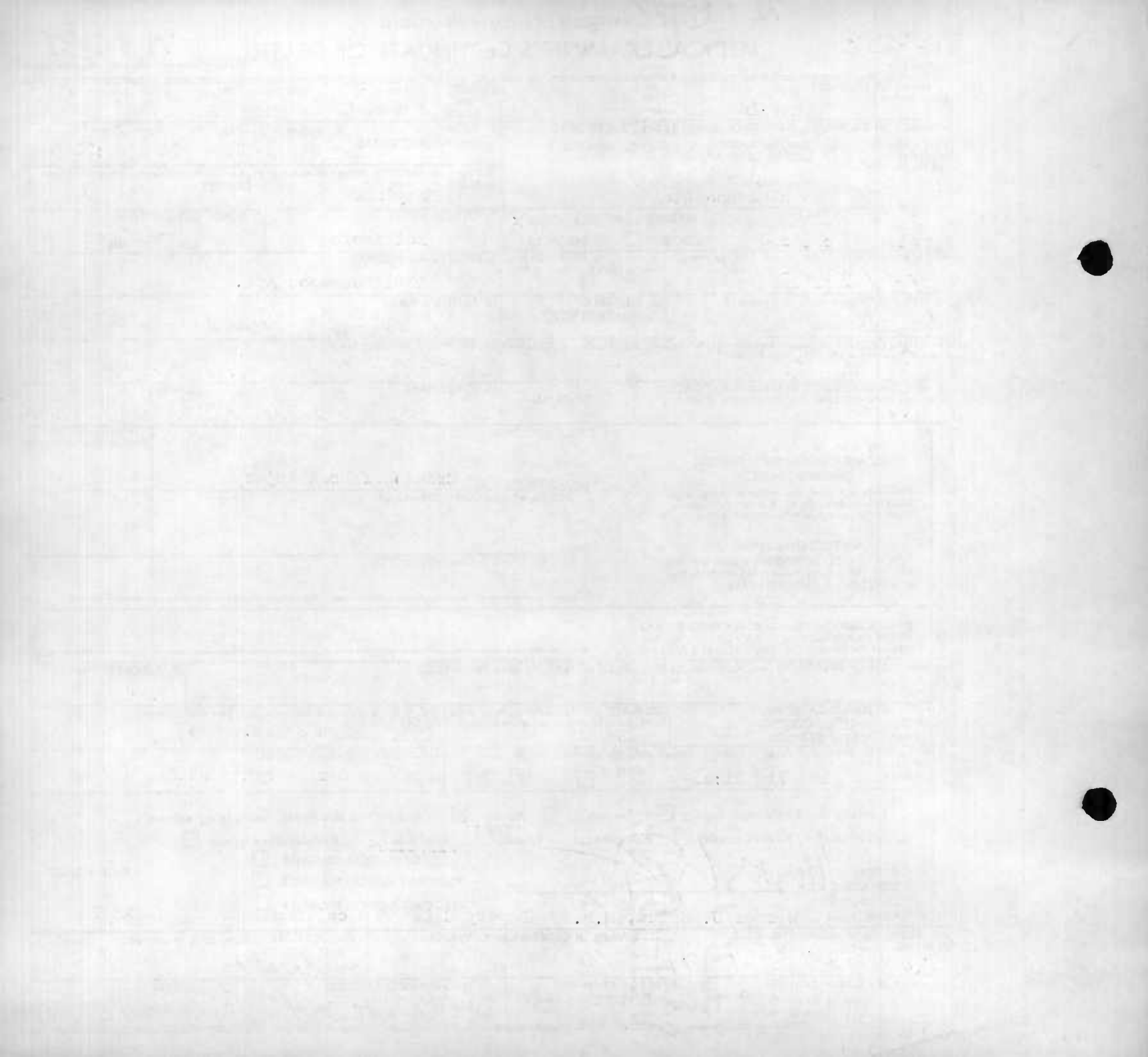
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-130		71 4138		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 4138	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Odeal Spady				2. DATE AND HOUR OF DEATH 4-26-71 12.30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1510			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3/ Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-22-16	
9. AGE (In years last birthday) 54		10. UNDER 1 Yr. Months Days		11. UNDER 24 Hrs. Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Ind.	
13. FATHER'S NAME Thaddeus Thomas				14. MOTHER'S MAIDEN NAME Sadie			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Records: BCH-4940 Eastern Avenue 21224	
18. 4360 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Multiple C.V.A. Hypertension		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sexual yn	
				(B) Possible C.V.A. DUE TO, OR AS A CONSEQUENCE OF:		Recent	
				(C) _____			
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Infolly medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4-29-71 to April 26, 1971 that (I) (we) last saw the deceased alive on 12-30-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE M. Haghsheenas				23B. DATE SIGNED April 26 71			
23C. PHYSICIAN'S NAME (Type) M. HAGHSHEENASS				23D. ADDRESS Bald. City Hospitals 21224			
24A. BURIAL CREMATION, REMOVAL, (Specify)		24B. DATE 4-30-71		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 29 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Elliott H. H. 1129 N. Calhoun St.		ADDRESS	



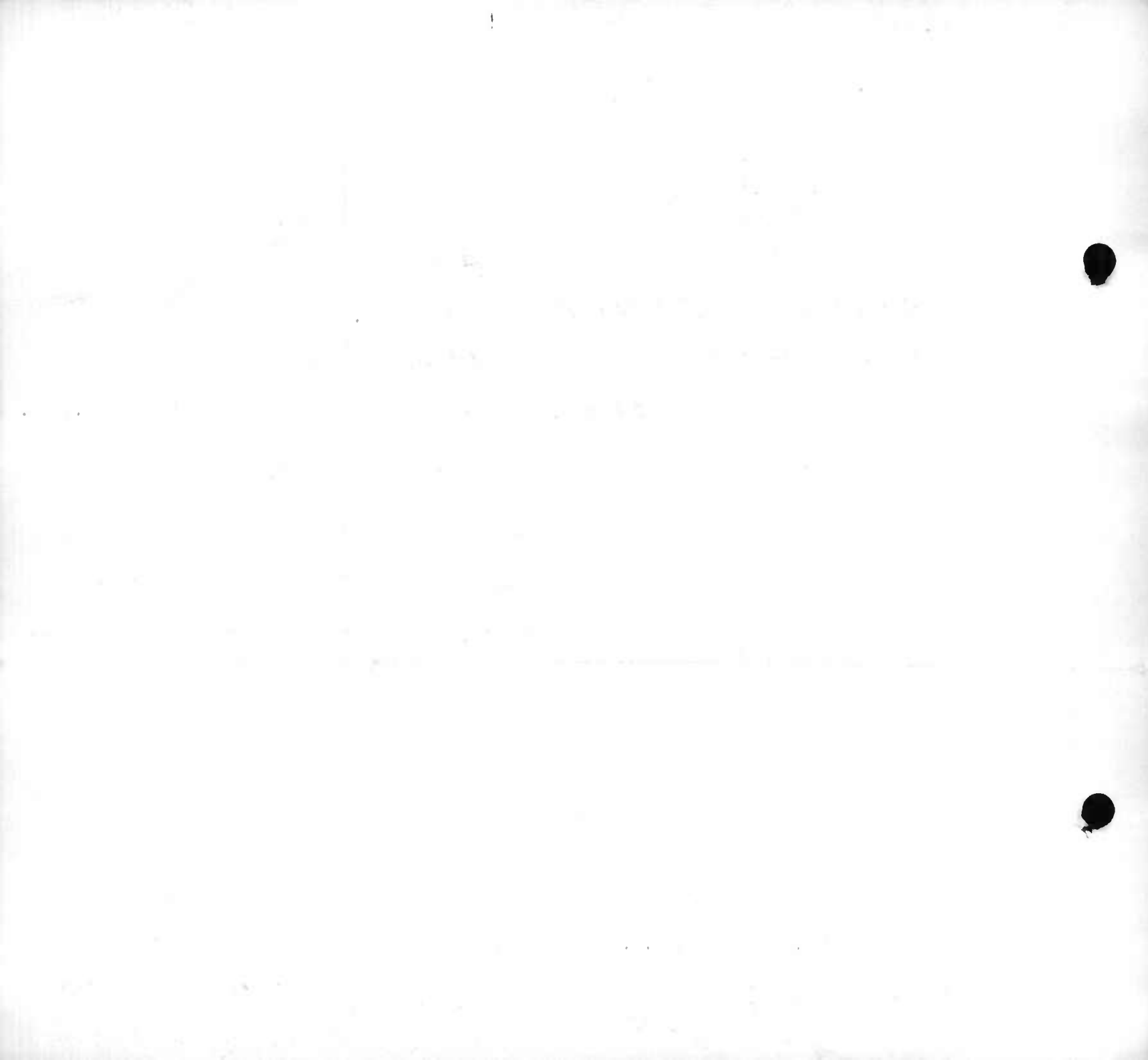
BALTIMORE CITY HEALTH DEPARTMENT																			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																			
REG. NO. 71 4137																			
BIRTH NO. G-300																			
1. NAME OF DECEASED (Type or Print) Ronald Goode					2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.														
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Hopkins Hospital					3. DATE PRONOUNCED DEAD Month Day Year Hour 4 27 71 3:22 p M.														
6. SEX male					7. RACE colored		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 909										
9. DATE OF BIRTH 4-15-55					10. AGE (In years lost birthday) 16		11. BIRTHPLACE (State or foreign country) Wash. D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.										
13. FATHER'S NAME William Goode					14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student					15. MOTHER'S MAIDEN NAME Doretha Greene									
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No					17. SOCIAL SECURITY NO. —		18. INFORMANT ADDRESS William Goode 1301 Homewood Ave.												
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E966 IX ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
(A) IMMEDIATE CAUSE Craniocerebral injury DUE TO, OR AS A CONSEQUENCE OF:																			
(B) DUE TO, OR AS A CONSEQUENCE OF:																			
(C) DUE TO, OR AS A CONSEQUENCE OF:																			
20A. DATE OF OPERATION 2										20B. CONDITION FOR WHICH OPERATION WAS PERFORMED									
21. AUTOPSY? (Yes or No) yes																			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) home					22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1301 Homewood Ave. 909									
22D. TIME (Month) (Day) (Year) (Hour) (APPROX.) 4 16 71 11:45 p.m.					22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>					22F. HOW DID INJURY OCCUR? stabbed during altercation									
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.										Deputy Chief Medical Examiner									
24A. BURIAL CREMATION, REMOVAL (Specify) Removal										24B. DATE 5-1-71									
24C. NAME OF CEMETERY OR CREMATORY										24D. LOCATION (City, town, or county) (State) Suffolk, Va.									
25A. DATE REC'D BY HEALTH DEPT. APR 29 1971										25B. NAME OF REGISTRAR Robert E. Jansen, M.D.									
25C. FUNERAL DIRECTOR										ADDRESS Elliott F. H. 1129 N. Caroline St.									



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 4138	
BIRTH NO. R-240		1. NAME OF DECEASED (Type or Print) Mrs. Nellie Sappington Russell		2. DATE AND HOUR OF DEATH April 27, 1971 2:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 19 The Seton Psychiatric Institute 6400 Wabash Avenue Baltimore, Maryland 21215			A. STATE Maryland B. COUNTY 2841		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 6400 Wabash Avenue,		
5. SEX Female	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-24-1898	9. AGE (in years last birthday) 73
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY		10B. KIND OF BUSINESS OR INDUSTRY INSURANCE		11. BIRTHPLACE (State or foreign country) Frederick Co., Maryland	
13. FATHER'S NAME Richard Cole Sappington				12. CITIZEN OF WHAT COUNTRY? United States	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				14. MOTHER'S MAIDEN NAME LAURA Garrett	
16. SOCIAL SECURITY NO. 213-03-3682				17. INFORMANT ADDRESS The Seton Psychiatric Institute, Balto., Md.	
18. 431.01 CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE Cerebral Hemorrhage				24 hours	
DUE TO, OR AS A CONSEQUENCE OF:					
(B) Cerebral arteriosclerosis				6 years	
DUE TO, OR AS A CONSEQUENCE OF:					
(C) Arterio-vascular Hypertension				12 years	
DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Schizophrenia, chronic, indifferntiated type 30 years					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 13, 1941 to April 27, 1971 that (I) (we) lost saw the deceased alive on April 27, 1971 and that (in) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Walter O. Jahrreiss, M.D.				23B. DATE SIGNED April 27, 1971	
23C. PHYSICIAN'S NAME (Type) Walter O. Jahrreiss, M.D.				23D. ADDRESS 6400 Wabash Avenue, Baltimore, Maryland 21215	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/30/71		24C. NAME OF CEMETERY or CREMATORY ST PETERS	
24D. LOCATION LIBERTYTOWN		24E. LOCATION (City, town, or county) (State) MD			
25A. DATE REC'D BY HEALTH DEPT. APR 29 1971		25B. NAME OF REGISTRAR Robert A. Taylor		25C. FUNERAL DIRECTOR Robert A. Taylor	
				ADDRESS LIBERTYTOWN	



MBJ 610
M-610
FUNERAL DIRECTOR: IMPORTANT
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>M-610</u>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>71 4188</u>	
1. NAME OF DECEASED (Type or Print)		ALSO KNOWN AS CAROLINE A. MURPHY MURPHY, CARRIE AGNES		2. DATE AND HOUR OF DEATH APRIL 26, 1971 7:55 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY Anne Arundel		5. STREET AND NUMBER 511 DOGWOOD ROAD	
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL		C. CITY OR TOWN LINTHICUM HEIGHTS		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02 17 94	9. AGE (in years last birthday) 77	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME MICHAEL HARDY		14. MOTHER'S MAIDEN NAME MARY ACOMB		12. CITIZEN OF WHAT COUNTRY? U S A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-09-4772D		17. INFORMANT BALTIMORE MD 21229 ST AGNES RECORDS WILKENS & CATON AVES	
18. <u>4124 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH CAUSE OF DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: QWA (B) ASCVD DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from APRIL 24 1971 to APRIL 26 1971 that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on APRIL 26 1971 and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.					
23A. SIGNATURE Donato A. Vargas Jr		23B. DATE SIGNED 04 26 71		23C. PHYSICIAN'S NAME (Type) DONATO A. VARGAS JR. M.D.	
23D. ADDRESS BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVES		23E. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-30-1971		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. APR 29 1971			
24F. NAME OF REGISTRAR Hubert E. Taylor, M.D.		24G. NAME OF REGISTRAR Hubert E. Taylor, M.D.			

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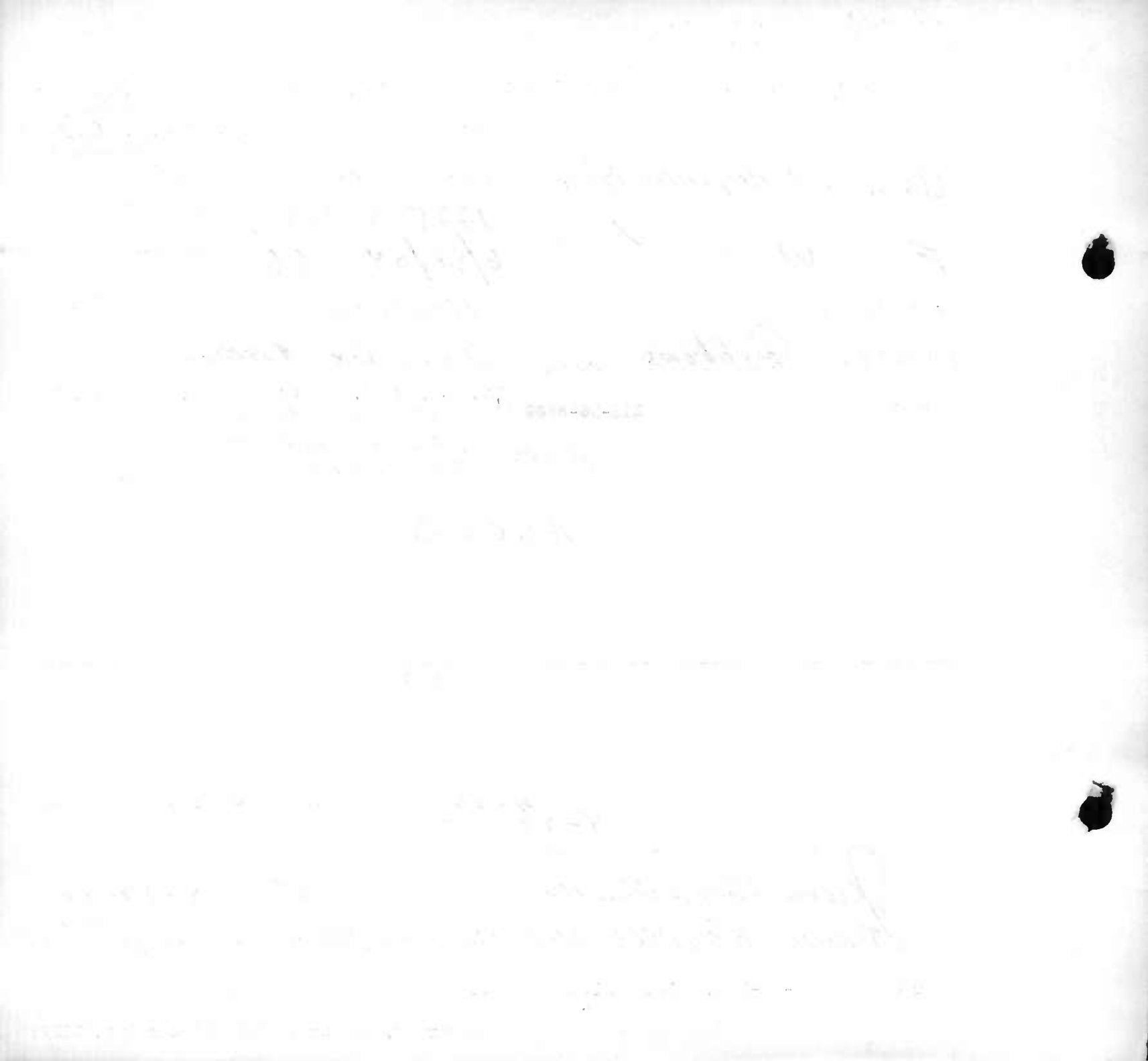
APRIL 1960

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4140	
BIRTH NO. 6-340		71 4140		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>PAULINE M GOTTAL</i>			2. DATE AND HOUR OF DEATH <i>4/27/71 12:25 AM</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>UNIV. of MARYLAND Hosp.</i>			A. STATE <i>MARYLAND</i> B. COUNTY <i>Baltimore City</i>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <i>1225 S. Carey St. 2102</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/21/04</i>	9. AGE (in years last birthday) <i>66</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Thomas</i>			14. MOTHER'S MAIDEN NAME <i>Isabelle</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>			16. SOCIAL SECURITY NO. <i>216-36-8680</i>		
			17. INFORMANT <i>Mr. Richard G. Gottal, 1225 S. Carey St. 21230</i>		
			ADDRESS <i>Hospital chart</i>		
18. <i>4/10/71</i>			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			<i>Acute ANTERIOR MYOCARDIAL INFARCTION</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>ASCVD</i>		
			(B) DUE TO, OR AS A CONSEQUENCE OF: <i>?</i>		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <i>4-26-71</i> to <i>4-27-71</i> and that (H) (we) last saw the deceased alive on <i>4-27-71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Norme Cooper</i>				23B. DATE SIGNED <i>4-27-71</i>	
23C. PHYSICIAN'S NAME (Type) <i>Berome Koepfel M.D.</i>				23D. ADDRESS <i>UNIV of Maryland Hosp</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4-30-1971</i>		24C. NAME of CEMETERY or CREMATORY <i>Loudon Park Cemetery</i>	
				24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 29 1971</i>		25B. NAME OF REGISTRAR <i>Berome Koepfel M.D.</i>		25C. FUNERAL DIRECTOR <i>Howard H. Hubbard, 4107 Wilkens Ave. 21229</i>	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 4141

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BRENDA L. JERRELL		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour April 24, 1971 7:15 A.M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Laurel	
9. DATE OF BIRTH August 24, 1950		10. AGE (In years lost birthday) 20 If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Norton, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		14B. KIND OF BUSINESS OR INDUSTRY Eastern Products	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 215-54-8193	
15. MOTHER'S MAIDEN NAME Iris Dean		18. INFORMANT Mr. Richard Amburgey	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Multiple Injuries		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 4-24-71		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED NO	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.) Street	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 4-24-71 5:20 A.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID IT IN Baltimore City, give exact location) South bound on Rte. 1.		22F. HOW DID INJURY OCCUR? Driver in auto fixed object collision	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		DATE SIGNED 4/24/71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/27, 1971	
24C. NAME OF CEMETERY or CREMATORY Meadowridge Memorial Park		24D. LOCATION (City, town, or county) (State) Howard County, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 29 1971		25B. NAME OF REGISTRAR John A. Galt	
25C. FUNERAL DIRECTOR Laurel Funeral Home Inc.		ADDRESS 550 Washington Blvd. of Howard M. Fleck Laurel, Md. 20810	

CONFIDENTIAL

ACADEMIC BOND

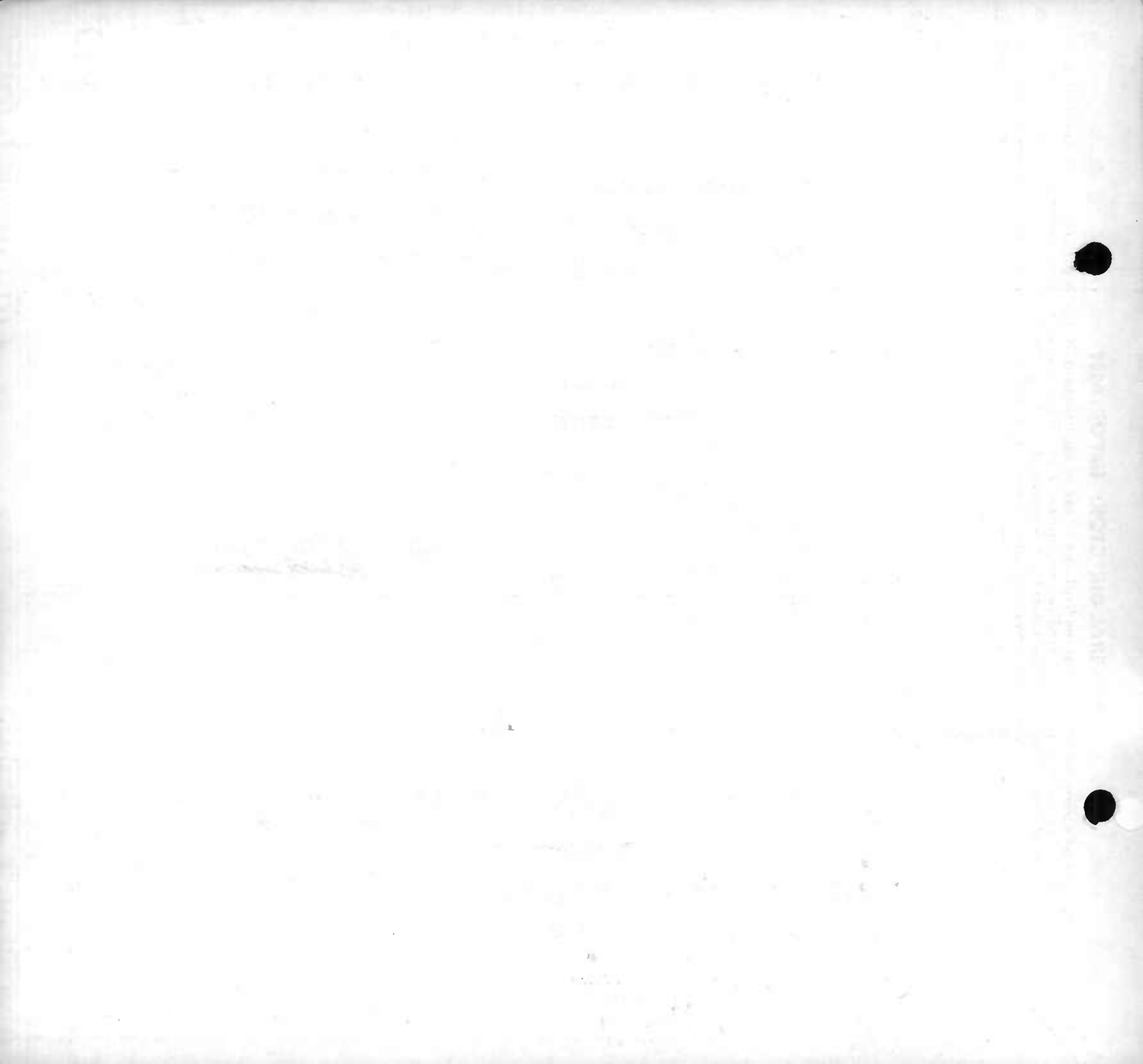
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

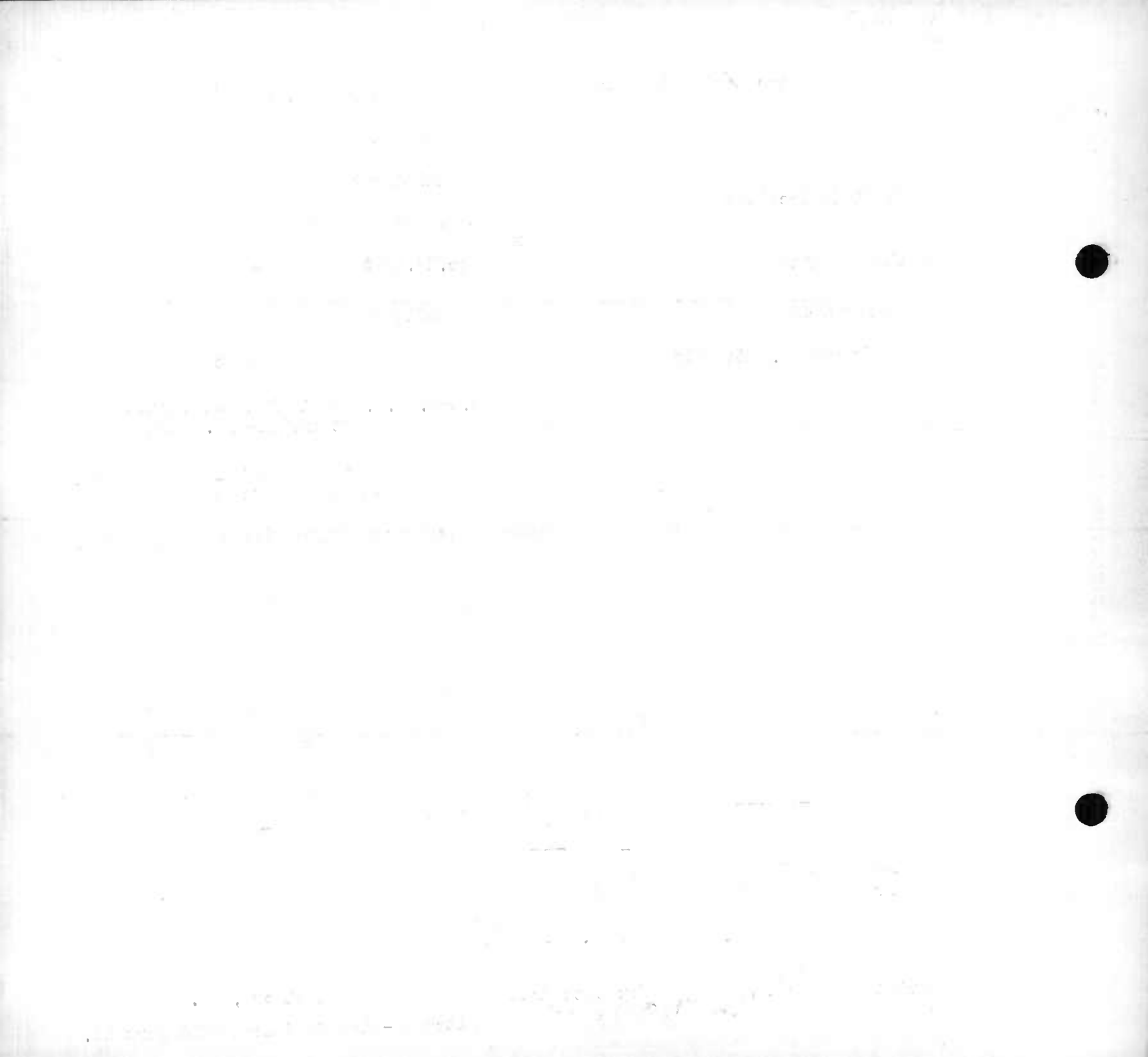
BALTIMORE CITY HEALTH DEPARTMENT				71 4142		REG. NO. 71 4142	
BIRTH NO. <u>K-145</u>				71 4142			
1. NAME OF DECEASED (Type or Print) <u>HENRY KAPLAN</u>				2. DATE AND HOUR OF DEATH <u>4-24-71</u> <u>5:40 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>-</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>44</u>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <u>Union Memorial Hospital</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>3027 MAYFIELD AVE.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-04-01</u>	9. AGE (In years last birthday) <u>69</u>	10. Under 1 Yr. Months: Days	11. Under 24 Hrs. Hours: Min.	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>JACOB KAPLAN</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>?</u>				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>MEDICAL RECORD</u>	
18. <u>44421</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>SEMI</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Severe pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF: <u>infarction</u> (C) <u>and intestinal obstruction</u>			
19. DATE OF OPERATION <u>21</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>		20A. AUTOPSY? (Yes or No) <u>- YES -</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (notify medical examiner) <u>- NO</u>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>-</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <u>-</u>				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>-</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>4-24</u> 19 <u>71</u> to <u>4-24</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>4-24</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (WE) (did) (didn't) view the body after death.							
23A. SIGNATURE <u>Lester A. Reid, M.D.</u>				23B. DATE SIGNED <u>4-24-71</u>		23C. PHYSICIAN'S NAME (Type) <u>LESTER A. REID M.D.</u>	
24A. SURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>4-28-71</u>		24C. NAME of CEMETERY or CREMATORY <u>Moreland Memorial Park</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>				25A. DATE REC'D BY HEALTH DEPT. <u>APR 29 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>				25C. FUNERAL DIRECTOR <u>John C. Miller Inc-6415 Belair Rd.-21206</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 4143</u>	
D-120 71 4143				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Miss Amelia du Bois		April 24, 1971	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE Maryland		
00 2801 Hemlock Ave			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 2647 Maryland Ave		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	If Under 1 Yr. Months Days
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Dec. 28, 1886	84	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Homemaker				England	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Leon J. du Bois			? Prince		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				Lt. Col. M.D. Dubois 1017 Jamieson Rd Lutherville Md. 21092	
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE Hypertensive cardio-vascular disease 10 yrs.		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Arteriosclerotic heart disease 10 yrs.		
			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from September 19 57 to April 24, 1971 that (I) (we) lost saw the deceased alive on April 1, 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Lloyd E. Saylor M.D.				Apr. 26, 1971	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Lloyd E. Saylor, M. D.		3902 Greenmount Avenue			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		4/27/71		New Cathedral	
				Baltimore, Md.	
25A. DATE AND TIME OF HEALTH DEPT. REGISTRATION		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 29 1971		J. E. Saylor, Jr.		Mitchell-Wiedefeld Home 6500 York Rd.	



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T-600 71 4144 BALTIMORE CITY HEALTH DEPARTMENT X

MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 4144

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Donald Terry		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 004 E. 32nd St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 25 71 12:55 a.m.	
6. SEX male		7. RACE white	
B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH April 14, 1929		10. AGE (In years lost birthday) 42	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate Broker		15. MOTHER'S MAIDEN NAME Ida M. Awalt	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes Korean War		17. SOCIAL SECURITY NO. 220-18-9217	
18. INFORMANT Mrs. Mary Ellen Mead		ADDRESS 99 Murdock Road	
19. CAUSE OF DEATH E9651X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) apt. house	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 4 E. 32nd St.		22F. HOW DID INJURY OCCUR? shot	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 4 24 71 Midnight		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner 4/25/71 ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 4/28/71	
24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 29 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home		ADDRESS 6500 York Road Balto. Md. 21212	

VS 151-REV. 1/1/68

April 14, 1939

Baltimore, Maryland

Head Finance Broker

John W. ...

Ida M. ...

Bernard E. ...

...

4/28/71 New Cathedral Cem.

Baltimore, Maryland

...

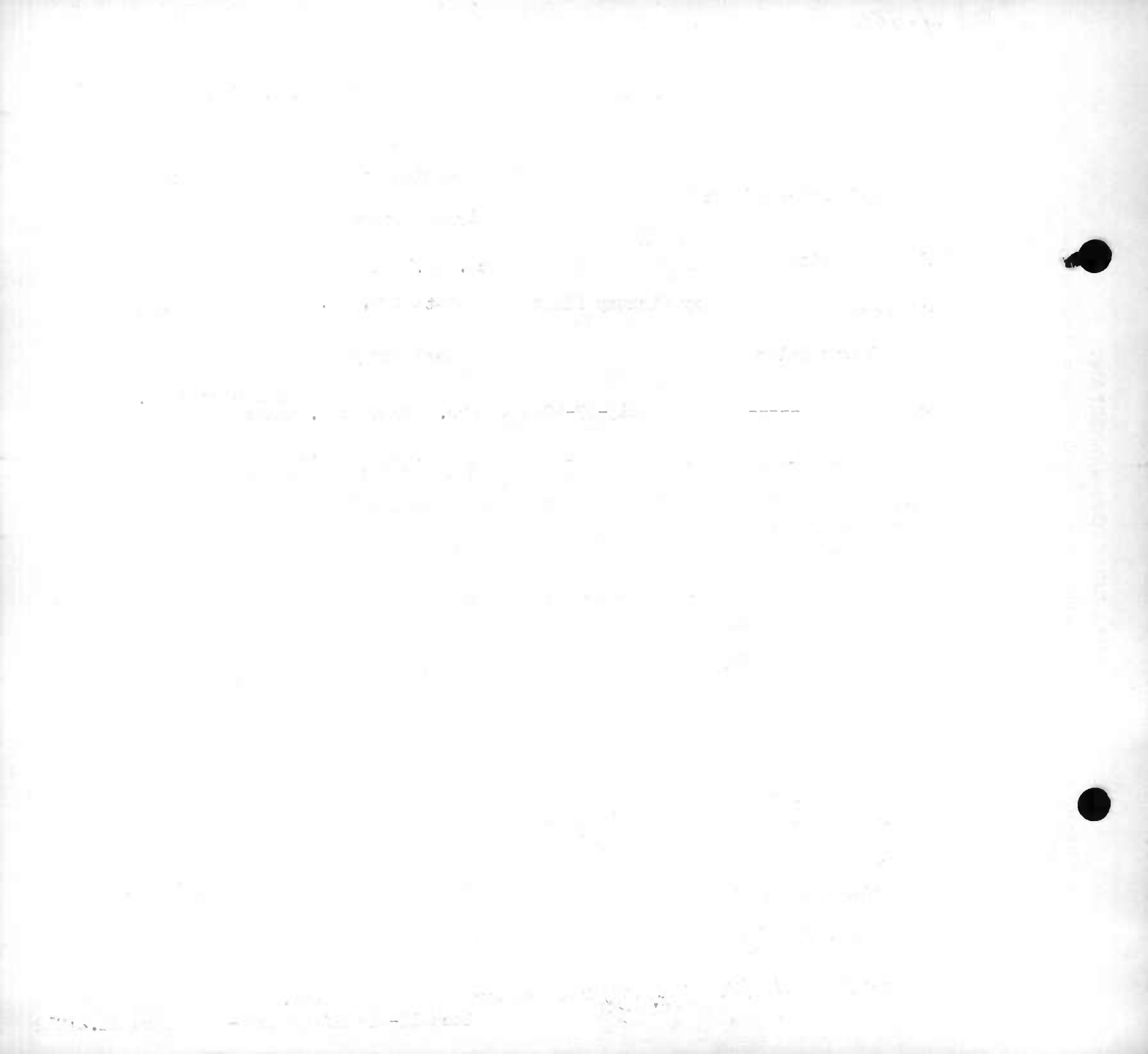
McNeill-McDonald House 6200 ...

...

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4145	
H-452		71 4145		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
HOWARD THOMAS HELMS		April 22nd, 1971 LP			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
00 1553 Burnwood Road		Maryland		2749	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		1553 Burnwood Road			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Oct. 19, 1901	69	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Boilmaker		Key Highway Plant BS		Baltimore, Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Thomas Helms		Rose Garey		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
no		215-07-4736 A		Mrs. Margaret M. Helms	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		Mediastinal Tumor - type undetermined			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
8				No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 20 February 1971 to 22 April 1971 that (I) (we) last saw the deceased alive on 22 April 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
John W. Barnaby				23 April 1971	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
JOHN W. BARNABY		1652 E. Blodgett Ave - 21239			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4/26/71		Cathedral Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 29 1971		John W. Barnaby		Mitchell-Wiedefeld Home-6500 York Rd. 21212	



BALTIMORE CITY HEALTH DEPARTMENT									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
REG. NO. 71 4146									
BIRTH NO.									
1. NAME OF DECEASED (Type or Print) John Hahn					2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 4 Day 26 Year 71 Hour 1:55 a.m.				
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION St. Agnes Hospital ADDRESS OR LOCATION 5-5-71 5-6-71					3. DATE PRONOUNCED DEAD Month 4 Day 26 Year 71 Hour 1:55 a.m.				
6. SEX male					7. RACE White				
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY AA 520				
9. DATE OF BIRTH Jan. 8, 1931					10. AGE (In years last birthday) 40				
11. BIRTHPLACE (State or foreign country) Md.					12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME HERBERT F. HAHN					14. MOTHER'S MAIDEN NAME Thelma Bernhardt				
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FUNERAL DIRECTOR					16. KIND OF BUSINESS OR INDUSTRY SELF				
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO					18. SOCIAL SECURITY NO. 217267490				
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Subdural hematoma					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Fatty metamorphosis of liver					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				
21. DATE OF OPERATION					22. CONDITION FOR WHICH OPERATION WAS PERFORMED				
23. AUTOPSY? (Yes or No) yes									
24. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.					25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) FUNERAL HOME				
26. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 4200 Pennington Ave. 2505					27. HOW DID INJURY OCCUR? Subject ran into steel door.				
28. TIME (Month) (Day) (Year) (Hour) (Approx.) 11-15-70 3:40 m.					29. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				
30. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					31. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>				
32. ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.					33. DATE SIGNED 4/26/71				
34. BURIAL CREMATION, REMOVAL (Specify) Burial					35. DATE 4/28/71				
36. NAME OF CEMETERY or CREMATORY Cedar Hill Cem					37. LOCATION (City, town, or county) Baltimore (State) Md.				
38. DATE REC'D BY HEALTH DEPT. APR 29 1971					39. NAME OF REGISTRAR				
40. FUNERAL DIRECTOR					41. ADDRESS				

V.S. 153 5-5-71 M.H.
Letter from M.E.'s office 5-6-71 M.H.

1

E-120 71 4147 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 4147

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MAUDE EPPS

2. DATE OF DEATH Known ☐ Month Day Year Hour
Estimated ☐ M.

3. DATE OF PRONOUNCED DEAD Month Day Year Hour
April 23, 1971 4:25 A.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF DECEASED (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 321 N. Monatsary Avenue

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE Maryland B. COUNTY

6. SEX Female 7. RACE Negro 8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☒ 9. DATE OF BIRTH April 30, 1926 10. AGE (In years lost birthday) 44 11. BIRTHPLACE (State or foreign country) Amelia, Virginia 12. CITIZEN OF WHAT COUNTRY? USA 13. FATHER'S NAME George D. Delaney

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic 14B. KIND OF BUSINESS OR INDUSTRY Private Family 15. MOTHER'S MAIDEN NAME Maude Cousin

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO 17. SOCIAL SECURITY NO. 230 52 1101 18. INFORMANT Gladys Clemmons 321 N. Monastery Ave

19. CAUSE OF DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
Cancer of Uterus
(A) IMMEDIATE CAUSE Cancer of the cervix with metastases
DUE TO, OR AS A CONSEQUENCE OF:
(B) DUE TO, OR AS A CONSEQUENCE OF:
(C) DUE TO, OR AS A CONSEQUENCE OF:

20. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) no

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 22F. HOW DID INJURY OCCUR?

23. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
ACTUAL SIGNATURE Isidore Mihalakis, M.D. CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. ASSISTANT MEDICAL EXAMINER ☒ DATE SIGNED 4/23/71
ASSOCIATE MEDICAL EXAMINER ☐

24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE Apr. 27, '71 24C. NAME OF CEMETERY or CREMATORY Chester Grove Cemetery 24D. LOCATION (City, town, or county) (State) Amelia, Virginia

25A. DATE REC'D BY HEALTH DEPT. APR 29 1971 25B. NAME OF REGISTRAR Robert E. Taylor, M.D. 25C. FUNERAL DIRECTOR ADDRESS LEWIS T GWYNN 4517 Park Heights Ave

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

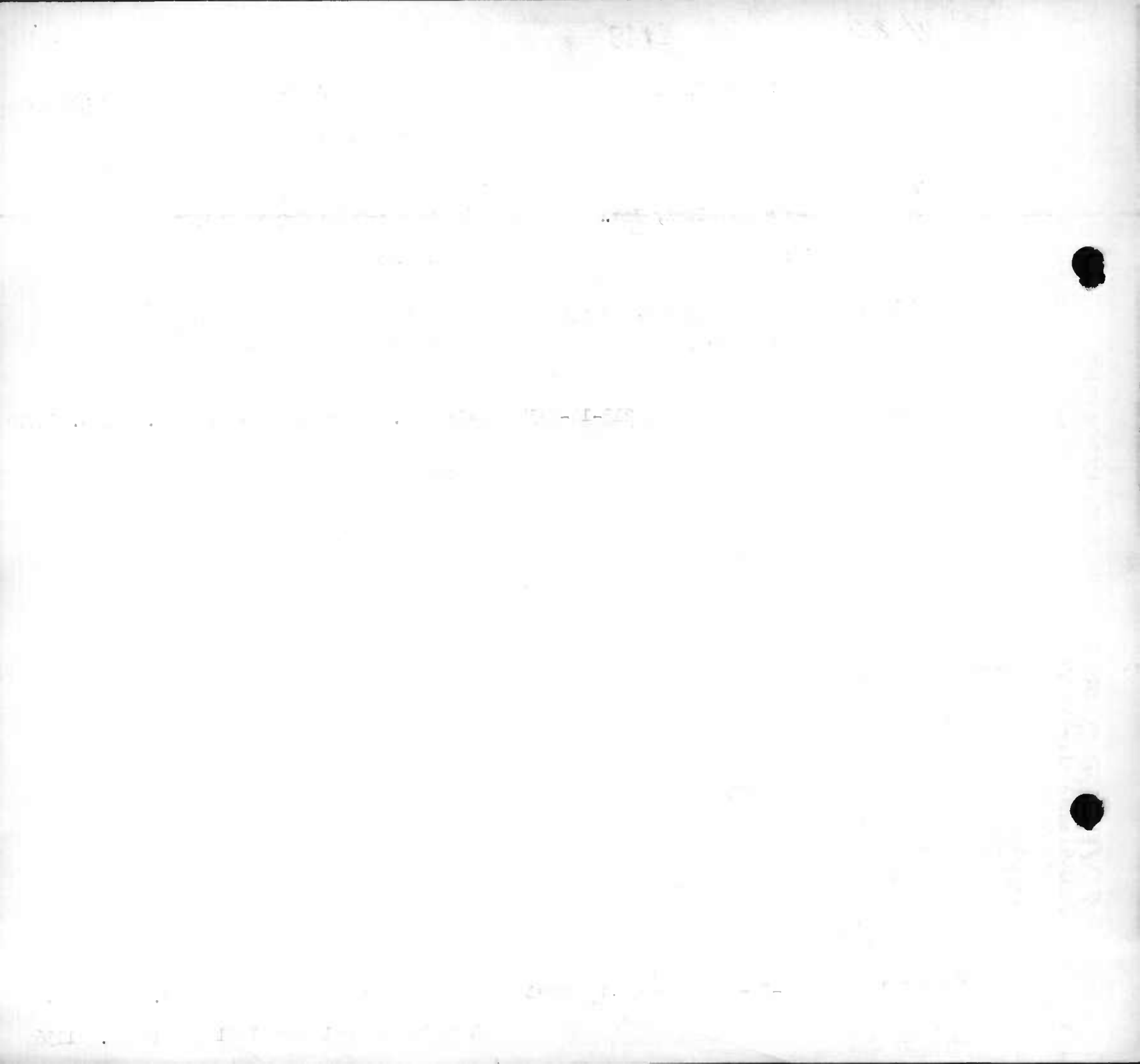
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 4148</u>	
BIRTH NO. <u>M-265 71 4148</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>MILDRED C. McGRAIN</u>		2. DATE AND HOUR OF DEATH <u>APRIL 27, 1971 5¹⁵ A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIV. OF MD. HOSP</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>1203</u>			
		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>435 E. 25th ST.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-29-98</u>	9. AGE (in years last birthday) <u>73</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WESTERN MD RR (RET)</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>R.R.</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
13. FATHER'S NAME <u>THOMAS McGRAIN</u>		14. MOTHER'S MAIDEN NAME <u>MARY TANYANE</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>HOSP CHART</u>	
18. <u>4/12/31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>ATHEROSCLEROTIC CORONARY ART. DIS</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>(A) IMMEDIATE CAUSE</u> <u>DUE TO, OR AS A CONSEQUENCE OF:</u> <u>(B) DUE TO, OR AS A CONSEQUENCE OF:</u> <u>(C) DUE TO, OR AS A CONSEQUENCE OF:</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>SUBACUTE BACTERIAL ENDOCARDITIS</u>				<u>? 1 month</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>APRIL 1 1971</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR	
22. I certify that (H) (this hospital) attended the deceased from <u>APRIL 1</u> 19 <u>71</u> to <u>APRIL 27</u> 19 <u>71</u> that (H) (we) last saw the deceased alive on <u>APRIL 27</u> 19 <u>71</u> and that (M) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Marvin J. Gordon</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4-27-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>MARVIN J. GORDON</u>		23D. ADDRESS <u>MD - DEPT OF MEDICINE, UNIV OF MD HOSP</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4/30/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>CATHEDRAL CEM</u>	
24D. LOCATION <u>BALTO</u>		24E. CITY, town, or county (State) <u>BALTO</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 29 1971</u>		25B. NAME OF REGISTRAR <u>John E. Jackson, M.D.</u>		25C. FUNERAL DIRECTOR <u>MITCHELL WIEDEFELD HOME - 6500 YORK RD</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

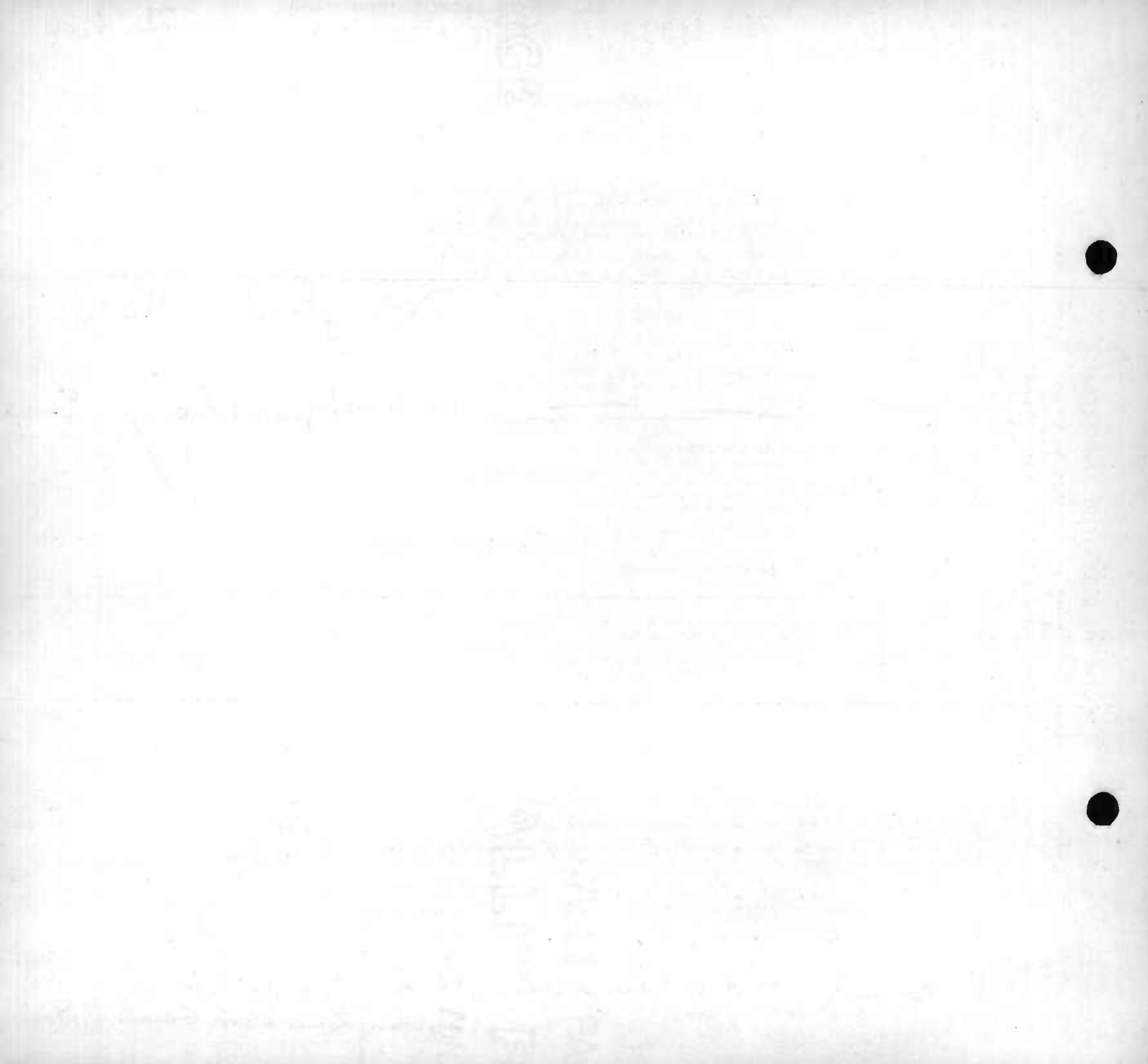
BALTIMORE CITY HEALTH DEPARTMENT										
71 4149 CERTIFICATE OF DEATH					X REG. NO. 71 4149					
1. NAME OF DECEASED (Type or Print) William Maser					2. DATE AND HOUR OF DEATH 4/27/71 6:30 P.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital, Inc.					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY AA CO. C. CITY OR TOWN Pasadena D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 4 Vista Mobile Drive #21122					
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-15-13		9. AGE (In years last birthday) 57		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder					10B. KIND OF BUSINESS OR INDUSTRY Sparrows Point					
11. BIRTHPLACE (State or foreign country) Maryland					12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME George Maser					14. MOTHER'S MAIDEN NAME Margaret Ortnung					
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 213-14-9534		17. INFORMANT ADDRESS Walter G. Maser 4220 Powell Ave. Balto. 21206			
18. CAUSE OF DEATH										
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>I</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 50%;"> <p>(A) IMMEDIATE CAUSE Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) Arteriosclerotic Myocardial Infarction</p> </div> </div>										
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>										
19A. DATE OF OPERATION 4/27/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?						
		White <input type="checkbox"/> Not White <input type="checkbox"/> At Work <input type="checkbox"/> At Home <input type="checkbox"/>								
22. I certify that (I) (this hospital) attended the deceased from 3/30 19 71 to 4/27 19 71 that (I) (we) lost the deceased on 4/27 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE Eloy B. Mander					23B. DATE SIGNED 4/27/71			23C. PHYSICIAN'S NAME (Type) Eloy B. Mander		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 4-30-71		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Parkville Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 29 1971			25B. NAME OF REGISTRAR Robert E. Taylor, M.D.			25C. FUNERAL DIRECTOR ADDRESS Lassahn Funeral Home 7401 Belair Rd. 21236				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

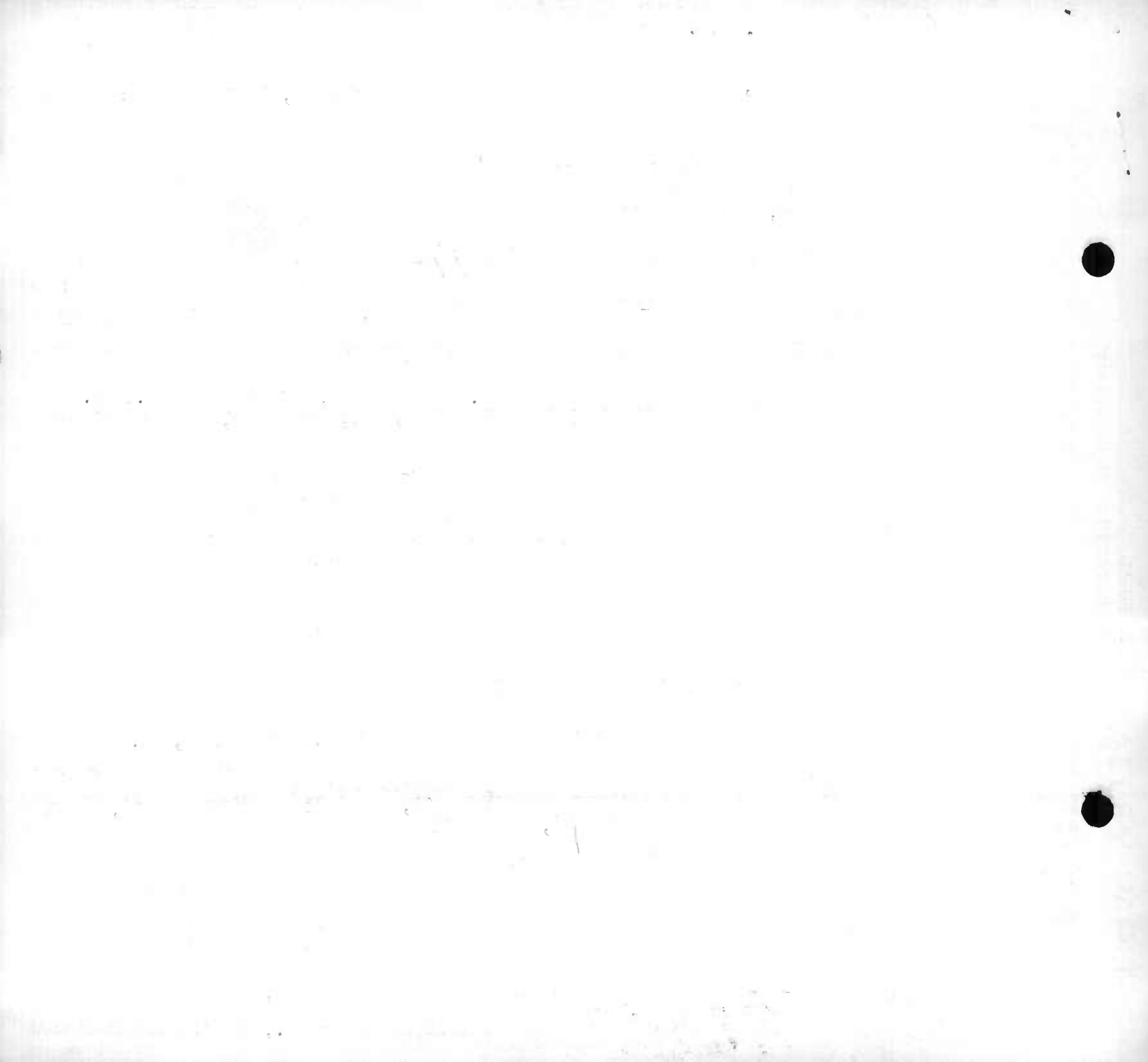
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	71 4150
BIRTH NO. <u>65-13223</u> 1. NAME OF DECEASED (Type or Print) <u>Naomi Rotenberg</u>		2. DATE AND HOUR OF DEATH <u>4/27, 1971</u> <u>8:15 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>The Johns Hopkins Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2740</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3501 Taney Road</u>			
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/2/65</u>	9. AGE (In years last birthday) <u>5</u>	If Under 1 Yr. Months: <u> </u> Days: <u> </u> If Under 24 Hrs. Hours: <u> </u> Min: <u> </u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Wolfgang Rotenberg</u>			
14. MOTHER'S MAIDEN NAME <u>Rena Rosenbaum</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u> </u>			
16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>M. Wolfgang Rotenberg</u> ADDRESS <u>Same</u>			
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 50%;"> (A) IMMEDIATE CAUSE <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF: <u>respiratory insufficiency</u> (B) <u>depauntonomic</u> DUE TO, OR AS A CONSEQUENCE OF: <u>from birth</u> (C) <u> </u> </div> </div>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>4/27/71</u> <u>19 71</u> to <u>4/27</u> <u>19 71</u> , that <u>(X)</u> (we) last saw the deceased alive on <u>4/27/71</u> <u>19 71</u> and that <u>(X)</u> (our) opinion death occurred on the date and hour and from the causes stated above <u>(X)</u> (We) (did) <u>(d/d not)</u> view the body after death.					
23A. SIGNATURE <u>Gail G. Shapiro, MD.</u>				23B. DATE SIGNED <u>4/27/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Gail G. Shapiro, MD.</u>		23D. ADDRESS <u>The Johns Hopkins Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/28/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Cherry Hill</u>	
24D. LOCATION (City, town, or county) <u>Randallstown</u>		24E. STATE <u>Md</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 29 1971</u>		25B. NAME OF REGISTRAR <u> </u>		25C. FUNERAL DIRECTOR <u>Sylvan Lewis & Son Garson, Md</u>	



FUNERAL DIRECTOR: IMPORTANT

VS 150-REV. 1/1/68

BIRTH NO.				BIRTH DATE				BIRTH TIME				BIRTH PLACE				BIRTH COUNTRY				BIRTH CITY				BIRTH STATE				BIRTH COUNTY				BIRTH ZIP				BIRTH CITY				BIRTH STATE				BIRTH COUNTY				BIRTH ZIP			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY				5. SEX				6. RACE				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH				9. AGE (In years lost birthday)				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?							
SPIERS, FRED A				April 26, 1971 10:50 P.M.				Veterans Administration Hospital 3900 Loch Raven Blvd Baltimore, Maryland 21218				MARYLAND				MALE				WHITE								7/10/12				58				DOMESTIC				AT HOME				BIRMINGHAM, ENGLAND				GREAT BRITAIN			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT				18. CAUSE OF DEATH				19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																											
DAVID SPIERS				ADA RANKIN				YES (CANADIAN) WW II				36-26-3686				MR. IRVIN PIERCE, 3612 BOWERS AVE., APT. B				(A) IMMEDIATE CAUSE Cardiac-pulmonary arrest				4/25/71																											
20. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				21. ANTECEDENT CAUSES				22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				23. DATE OF OPERATION				24. CONDITION FOR WHICH OPERATION WAS PERFORMED				25. AUTOPSY? (Yes or No)				26. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																											
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)								4/23/71				Quadruplegia & brachycardia				NO																															
27. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				28. INJURY OCCURRED				29. HOW DID INJURY OCCUR?				30. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				31. DATE OF INJURY (APPROX.)				32. TIME OF INJURY (APPROX.)				33. DATE OF DEATH																											
hospital				While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>				Fell during transfer from bedside chair to bed				VA Hospital, Fort Howard, Md.				4/20/71				4/20/71				4/27/71																											
34. I certify that (A) (this hospital) attended the deceased from				35. (We) last saw the deceased alive on				36. and that (B) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (C) (We) (did) (not) view the body after death.				37. SIGNATURE				38. DATE SIGNED				39. PHYSICIAN'S NAME (Type)				40. ADDRESS																											
M. Sankarati				APRIL 23, 1971				APRIL 26, 1971				M. Sankarati				4/27/71				MEHDI SANKARATI				3900 Loch Raven Boulevard Baltimore, Maryland 21218																											
41. BURIAL CREMATION, REMOVAL (Specify)				42. DATE				43. NAME of CEMETERY or CREMATORY				44. LOCATION (City, town, or county)				45. DATE REC'D BY HEALTH DEPT.				46. NAME OF REGISTRAR				47. FUNERAL DIRECTOR				48. ADDRESS																							
BURIAL				4-28-71				HEBREW FRIENDSHIP				BALTIMORE, MARYLAND				APR 29 1971				J. S. Sankarati				SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD																											



FUNERAL DIRECTOR: IMPORTANT

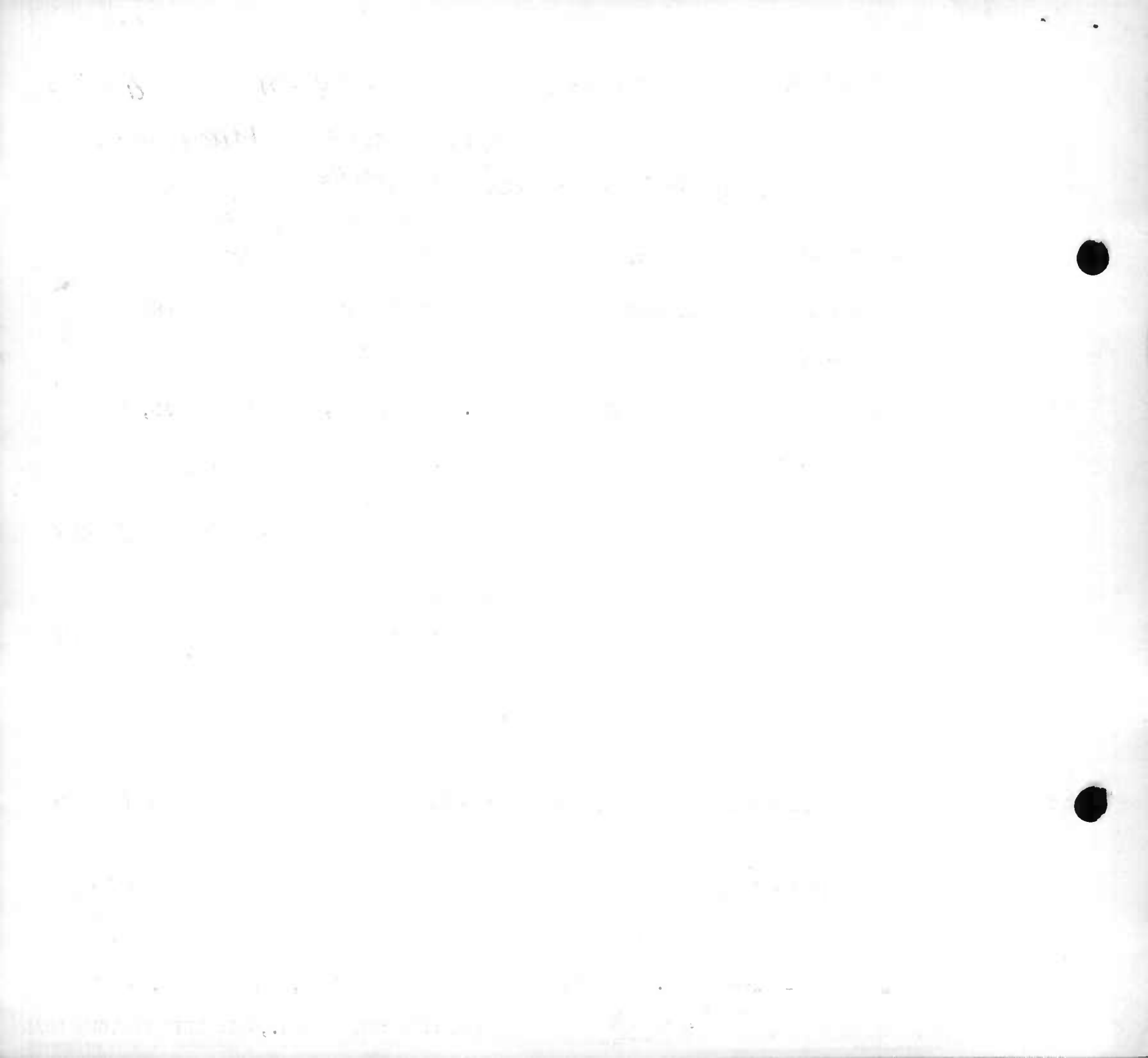
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-416 71 4152		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 4152	
1. NAME OF DECEASED (Type or Print) MEYER SILVERMAN		2. DATE AND HOUR OF DEATH 4.26. 1971 11.55 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 Church Home & Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. BALTO. B. COUNTY 5300			
		C. CITY OR TOWN Balt.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER XXXXXXXXXXXXXXX 2533 FARRINGTON ROAD			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-8-07	9. AGE (in years last birthday) 63	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXXXXXXXXXXXXX RETIRED		10B. KIND OF BUSINESS OR INDUSTRY CLERK		11. BIRTHPLACE (State or foreign country) BALTO. MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Julius Silverman			
14. MOTHER'S MAIDEN NAME ROSE Friedman		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. II			
16. SOCIAL SECURITY NO.		17. INFORMANT SIDNEY SILVERMAN ADDRESS 2533 Farrington Rd			
18. 412.51 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) A.S.H.D		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CVA Cardiac arrhythmia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the underlying condition last. II		(B) DUE TO, OR AS A CONSEQUENCE OF: gr Arteriosclerosis		(C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (4) (this hospital) attended the deceased from 4.2 19 71 to 4.26 19 71 that (4) (we) last saw the deceased alive on 4.26 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Abdus Samad MD				23B. DATE SIGNED 4.26. 1971	
23C. PHYSICIAN'S NAME (Type) ABDUS SAMAD MD		23D. ADDRESS MD Church Home & Hospital Balt. MD 2121			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 4-28-71	24C. NAME of CEMETERY or CREMATORY ANSHE EMUNAH		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. APR 29 1971		25B. NAME OF REGISTRAR John R. Fisher, M.D.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

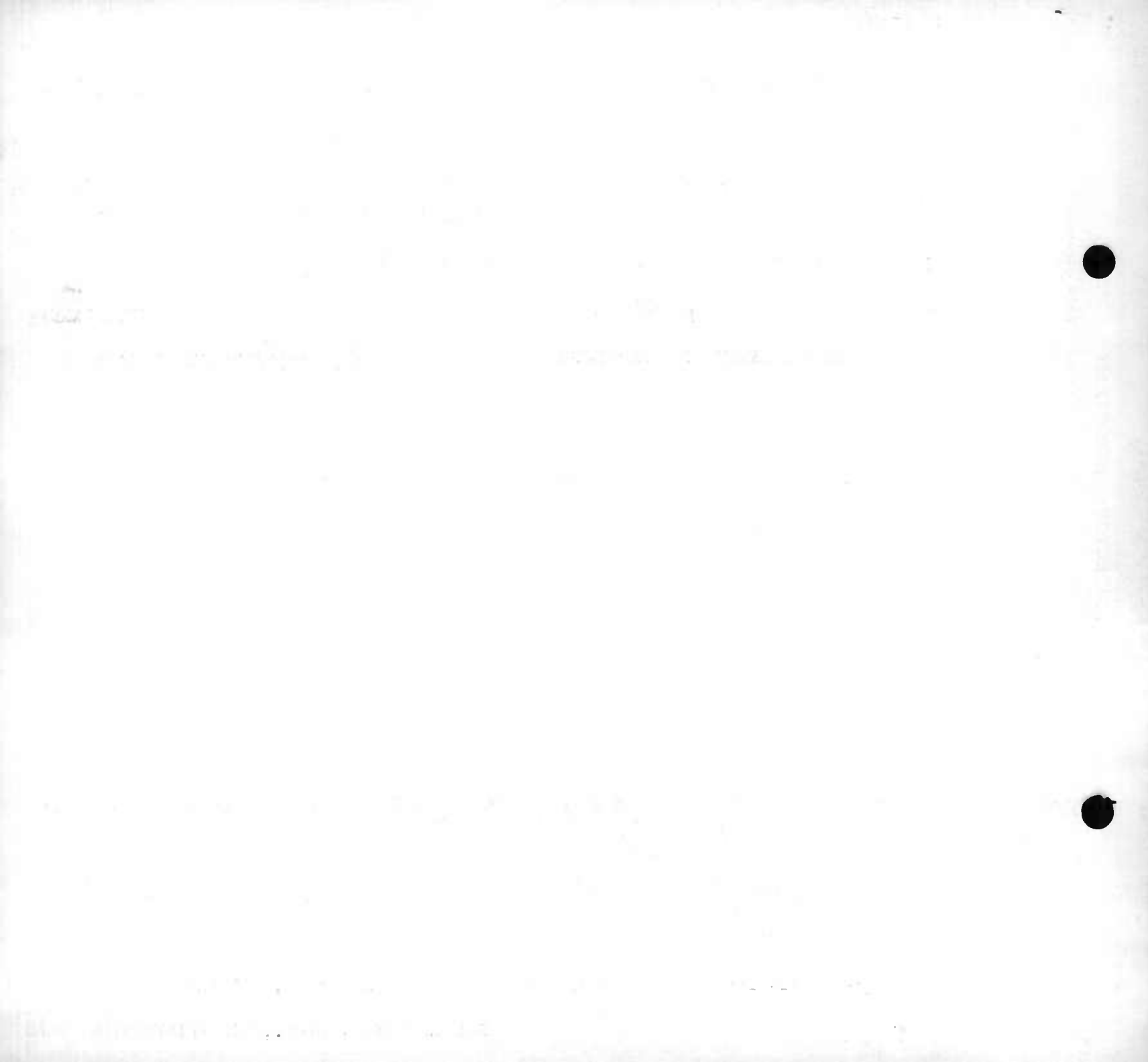
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 4153
U-239 71 4153		BIRTH NO.		
1. NAME OF DECEASED (Type or Print) DORA WACHTEL		2. DATE AND HOUR OF DEATH 4-28-71 10:45 am		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		
FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital of Balt		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		8. DATE OF BIRTH 4-27-81 9. AGE (in years last birthday) 90 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) NEW YORK CITY		12. CITIZEN OF WHAT COUNTRY USA		
13. FATHER'S NAME LOUIS AARON		14. MOTHER'S MAIDEN NAME ANN ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT MR. IRVIN DUBIN, 5706 RANNY ROAD, #21209
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CARDIAC ARRHYTHMIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 MINUTES		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ABEROSCELOTIC CARDIOVASCULAR DISEASE		(B) DUE TO, OR AS A CONSEQUENCE OF: YEARS		
(C) _____		_____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). PNEUMONIA		_____		
19A. DATE OF OPERATION 4/28/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 4/26/71 19 71 to 4-28 19 71 that (I) (we) last saw the deceased alive on 4/28 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE WUBEN DENANSKI		23B. DATE SIGNED 4/28/71		23C. PHYSICIAN'S NAME (Type) WUBEN DENANSKI
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL-BURIAL		24B. DATE 4-29-71		24C. NAME OF CEMETERY or CREMATORY MT. ZION (LEMBERGER VEREIN)
24D. LOCATION (City, town, or county) (State) MASPETH, LONG ISLAND, NEW YORK		25A. DATE REC'D BY HEALTH DEPT. APR 29 1971		
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

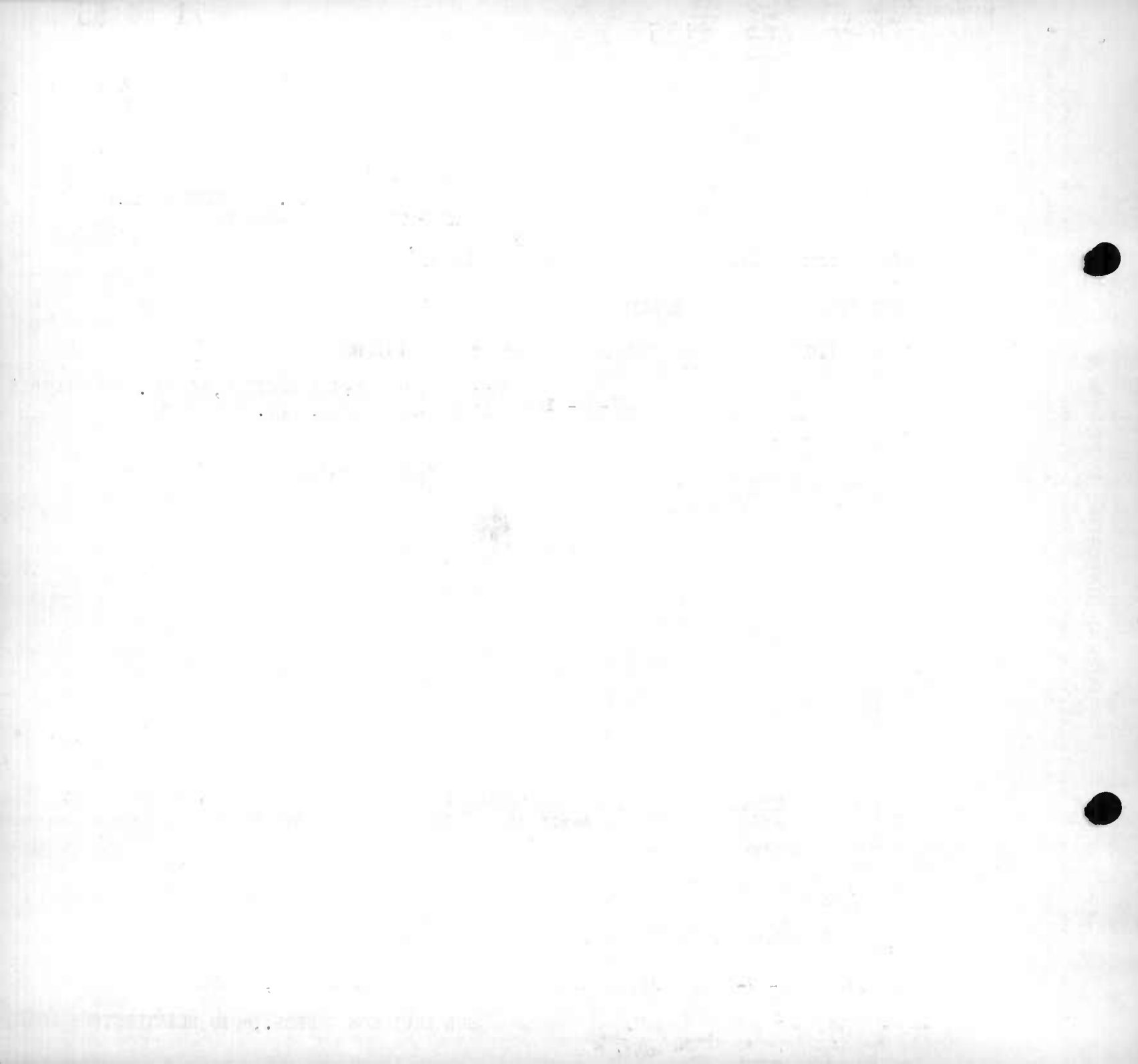
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 4154</u>	
K-536 BIRTH NO. <u>71 4154</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Eva Kantorow</u>		2. DATE AND HOUR OF DEATH <u>4/27/71</u> <u>2:15 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Sinai Hospital</u>		A. STATE <u>MD.</u>		B. COUNTY <u>BALTO.</u>	
		C. CITY OR TOWN <u>BALTO. MD.</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <u>6524 SANZO RD # 21209</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-01-04</u>	9. AGE (In years last birthday) <u>66</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>Russia</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>XXXXXXXXXX ? GARFINKEL</u>		14. MOTHER'S MAIDEN NAME <u>XXXXXXXXXXXXXXX UNKNOWN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Son (Bennett) Same</u>	
18. <u>7-2-21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Cardiac Arrest</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Heart Failure</u>		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Inotify medical examiner <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>April 25</u> 19 <u>71</u> to <u>April 27</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>April 27</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>4/27/71</u>			
23C. PHYSICIAN'S NAME (Type) <u>H. Roser MD</u>		23D. ADDRESS <u>Sinai Hospital Baltimore</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4-28-71</u>		24C. NAME of CEMETERY or CREMATORY <u>HEBREW YOUNG MEN</u>	
		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 29 1971</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4155	
BIRTH NO. G-200 71 4155		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Joseph Goz			2. DATE AND HOUR OF DEATH 4-25-1971 4:55 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 91 Levindale			A. STATE MARYLAND B. COUNTY 1701		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 532W. MULBERRY STREET		
5. SEX MALE	6. RACE Human	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 2, 1888	9. AGE (In years last birthday) 82	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10B. KIND OF BUSINESS OR INDUSTRY RETAIL		11. BIRTHPLACE (State or foreign country) Russia	
13. FATHER'S NAME MENDEL GOZ			14. MOTHER'S MAIDEN NAME ? LIFSNE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 401-20-9182		17. INFORMANT HEBREW FREE BURIAL SOCIETY, c/o MR. MOSE MORRIS	
				ADDRESS 3737 CLARKS LANE, APT. 101 #21215	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) 560.2 I			CAUSE OF DEATH (A) IMMEDIATE CAUSE Jejunal Torsion DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Home <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 5, 1961 to April 25, 1971 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 25, 1971 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE Theodore R. Reiff, M.D.			23B. DATE SIGNED April 26, 1971		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS Levindale		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-27-71		24C. NAME OF CEMETERY or CREMATORY BALTIMORE HEBREW	
24D. LOCATION BALTIMORE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. APR 29 1971			
25B. NAME OF REGISTRAR Sol Levinson & Bros.		25C. FUNERAL DIRECTOR ADDRESS 6010 REISTERSTOWN ROAD			



1

Y-620 71 4156 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 4156

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ANNA YORK		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MARYLAND GENERAL HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour April 26, 1971 11:55 A.M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Dec. 22, 1885		10. AGE (In years lost birthday) 85	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Mkr		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 218-07-03778	
18. INFORMANT Lillian Stachowski (Stack)		ADDRESS 6919 Gough Street	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		CAUSE OF DEATH Arteriosclerotic cardiovascular disease	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-29-71	
24C. NAME OF CEMETERY or CREMATORY Ebenezer Cemetery		24D. LOCATION (City, town, or county) (State) Chase, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 29 1971		25B. NAME OF REGISTRAR John C. Miller Inc-6415 Belair Rd.-21206	
25C. FUNERAL DIRECTOR		ADDRESS	

VS 151-REV. 1/1/68

WALLACE & GORDON

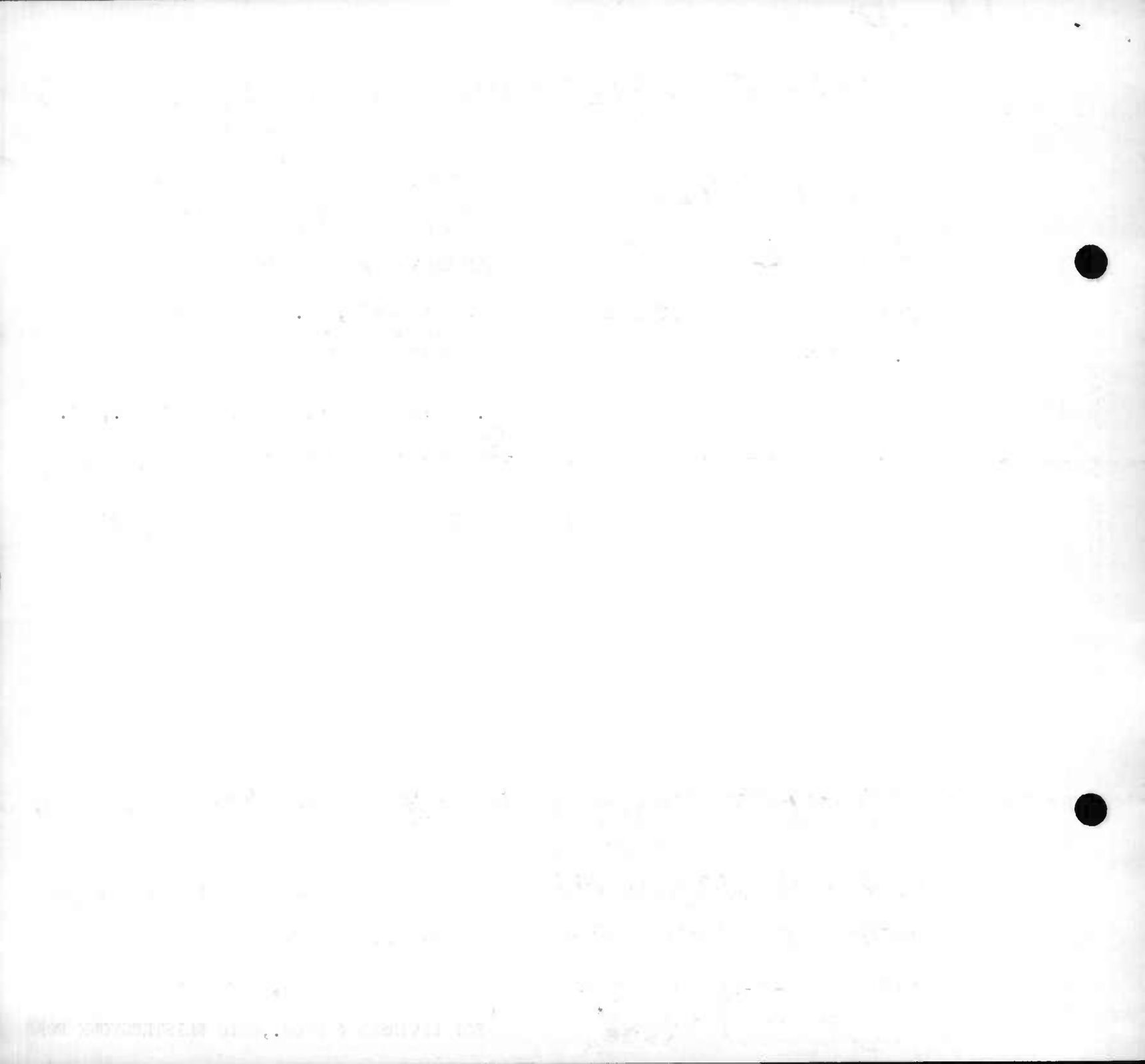
25/4/1961

1001 X 1001

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

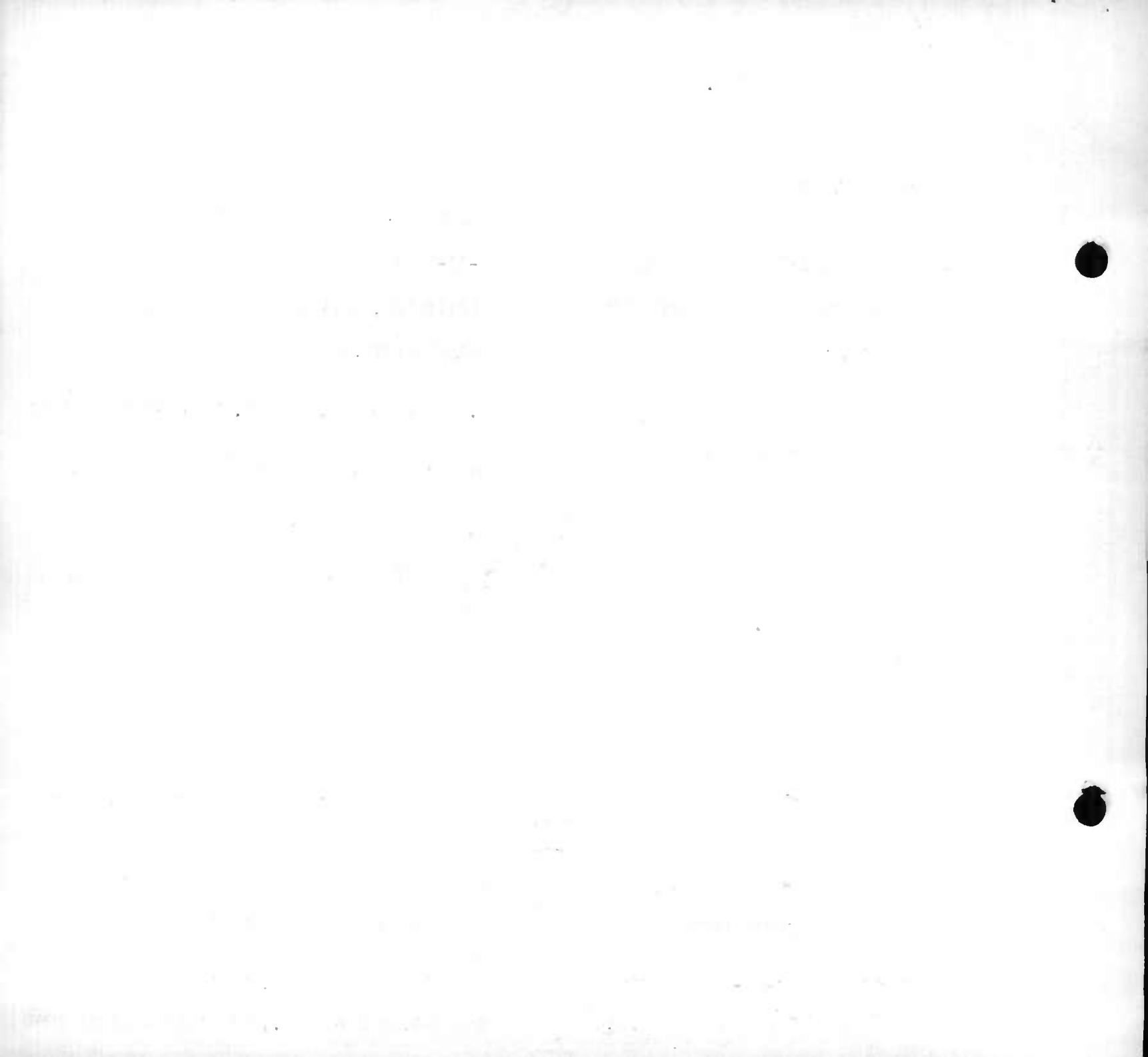
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 4157	
7-635 71 4157		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) SOPHIE FRIEDMAN		2. DATE AND HOUR OF DEATH 28 APRIL 1971 7:35 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 2740 C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3113 BANCROFT RD.	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH XXXXXX
9. AGE (In years last birthday) 69		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
11. BIRTHPLACE (State or foreign country) PHILADELPHIA, PA.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WM. SHAPIRO		14. MOTHER'S MAIDEN NAME SARAH ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT MR. LOUIS FRIEDMAN, 3113 BANCROFT RD., APT. F		ADDRESS	
18. 4-12-71 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH CEREBRAL THROMBOSIS (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 HRS YEARS	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION 6		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOFSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (in this hospital) attended the deceased from 26 April 1971 to 28 April 1971 that (we) last saw the deceased alive on 28 April 1971 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Arthur M. Wagner, M.D.		23B. DATE SIGNED 28 APRIL 71	
23C. PHYSICIAN'S NAME (Type) ARTHUR M. WAGNER M.D.		23D. ADDRESS SINAI HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-29-71	
24C. NAME OF CEMETERY or CREMATORY OHEL YAKOV		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. APR 29 1971		25B. NAME OF REGISTRAR John E. Fisher, M.D.	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 4158</u>	
H-632 71 4158				CERTIFICATE OF DEATH	
BIRTH NO. <u>4-632</u>		1. NAME OF DECEASED (Type or Print) <u>SHIRLEY F. HURWITZ</u>		2. DATE AND HOUR OF DEATH <u>4/28/71 @ 1:30 PM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SINAI HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2730</u>	
5. SEX <u>FEMALE</u>		6. RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>9-21-1904</u>		9. AGE (in years last birthday) <u>66</u>		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>MAX FREED</u>		14. MOTHER'S MAIDEN NAME <u>HANNAH RAFFEL</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MR. DAVID GERBER, 326 ST. PAUL STREET #21202</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Acute Coronary Occlusion</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Hypertensive heart Dis.</u> <u>Hypertension</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 yrs</u> <u>15 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1955</u> to <u>Apr 28 1971</u> that (I) (we) last saw the deceased alive on <u>Apr 28 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Jonas Cohen</u>		23B. DATE SIGNED <u>4/28/71</u>		23C. PHYSICIAN'S NAME (Type) <u>JONAS COHEN</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4-29-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>CHIZUK AMUNO (ARLINGTON)</u>	
24D. LOCATION <u>BALTIMORE, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 29 1971</u>		25B. NAME OF REGISTRAR <u>John A. Kelly</u>	
25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>		25D. ADDRESS		25E. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>	



FUNERAL DIRECTOR: IMPORTANT

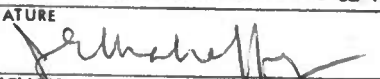
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

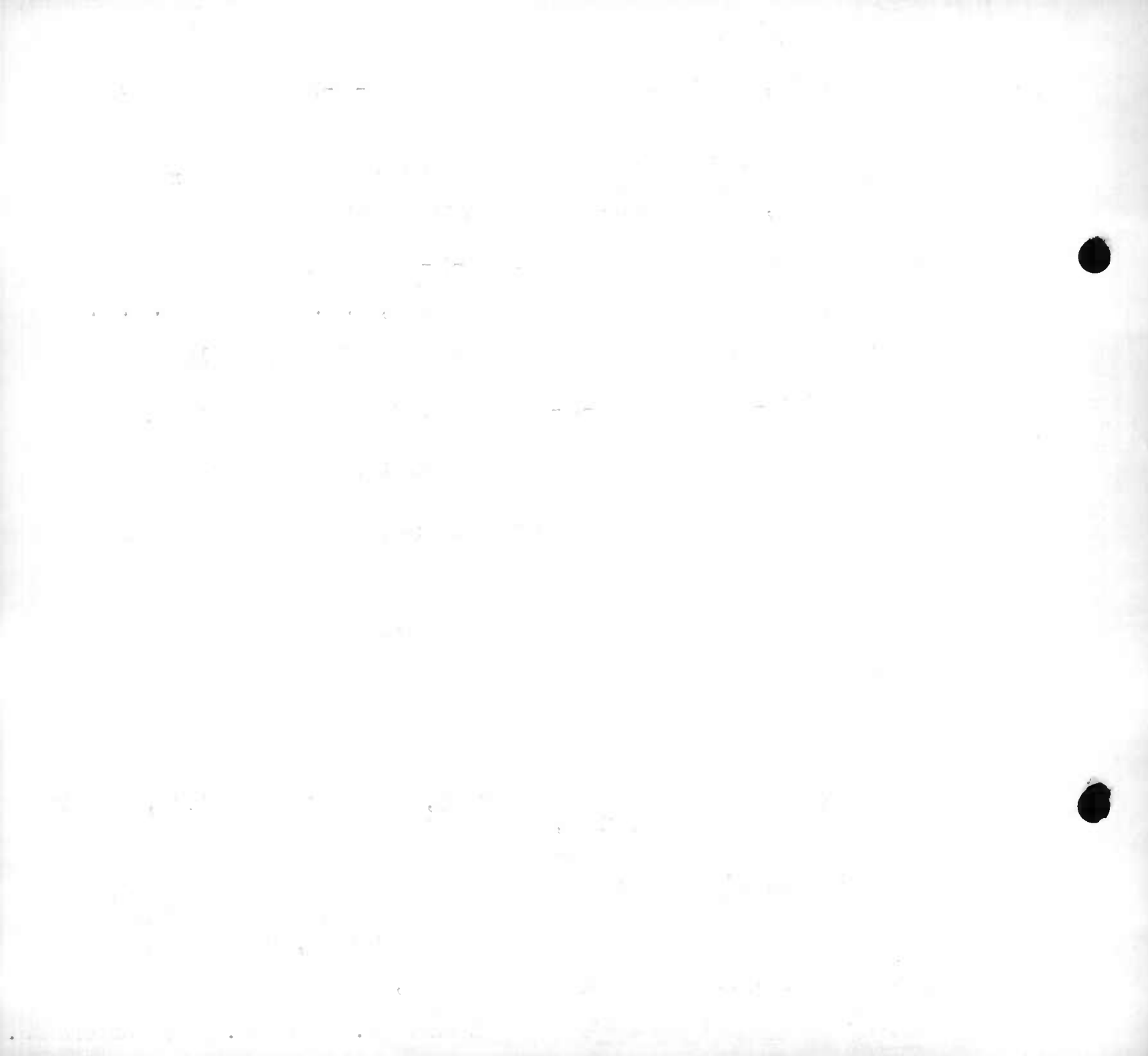
BALTIMORE CITY HEALTH DEPARTMENT									
71 4158					71 4158				
BIRTH NO.					REG. NO.				
1. NAME OF DECEASED (Type or Print) Louis Violi					2. DATE AND HOUR OF DEATH April 28, 1971 2:05 P.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY 2743				
5. SEX M 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 10-26-08 9. AGE (In years last birthday) 62				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President Violi Bro. Inc					11. BIRTHPLACE (State or foreign country) Maryland				
13. FATHER'S NAME Louis A. Violi					14. MOTHER'S MAIDEN NAME Elizabeth Forster				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 216-01-0705				
17. INFORMANT Mrs Mary W Violi					ADDRESS Same				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
(A) IMMEDIATE CAUSE DIFFUSE CARCINOMATOSIS									
(B) DUE TO, OR AS A CONSEQUENCE OF: ADENOCARCINOMA OF THE PANCREAS.									
(C) NONE									
19. DATE OF OPERATION NONE 20. CONDITION FOR WHICH OPERATION WAS PERFORMED NONE					21. AUTOPSY? (Yes or No) YES				
22. I certify that (I) (this hospital) attended the deceased from 3-21-1971 to 4-28-1971					23. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES				
24. I certify that (I) (we) lost saw the deceased alive on 4-28-1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
25. SIGNATURE Joseph D. Notarangelo M.D.					26. DATE SIGNED 4-29-1971				
27. PHYSICIAN'S NAME (Type) JOSEPH D. NOTARANGELO M.D.					28. ADDRESS 301 ST. PAUL PLACE 21202				
29. BURIAL CREMATION, REMOVAL (Specify) Burial					30. DATE 5/1/71				
31. NAME OF CEMETERY OR CREMATORY Holy Redeemer					32. LOCATION (City, town, or county) (State) Baltimore, Maryland				
33. DATE REC'D BY HEALTH DEPT. APR 29 1971					34. NAME OF REGISTRAR Robert E. Talley				
35. FUNERAL DIRECTOR Leonard J. Ruck Inc.					ADDRESS Baltimore, Md				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-626 71 4160		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 4160	
1. NAME OF DECEASED (Type or Print) BURGHARDT, Joseph MN		2. DATE AND HOUR OF DEATH 4-28-71 8:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218		A. STATE Maryland		B. COUNTY Balto.	
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 7814 Oak Avenue			
5. SEX Male	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 8-13-18	9. AGE (in years last birthday) 52
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York, N. Y.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Valentine Burghardt			
14. MOTHER'S MAIDEN NAME Catherine Mormilo Mormilo		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 8/25/41 - 11/3/44			
16. SOCIAL SECURITY NO. 130-01-7769		17. INFORMANT VA Hospital Records Baltimore, Md 21218			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 019.01-503.2		CAUSE OF DEATH (A) IMMEDIATE CAUSE E coli bilateral pneumonia DUE TO, OR AS A CONSEQUENCE OF: OBSTRUCTIVE (B) Chronic lung disease DUE TO, OR AS A CONSEQUENCE OF: (C) MOD. SEVERE PULMONARY TUBERCULOSIS INACTIVE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days 4 years	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Chronic alcoholism			
19A. DATE OF OPERATION 4/27/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED tracheostomy		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that ID (this hospital) attended the deceased from April 13, 1971 to April 28, 1971 that HE (we) last saw the deceased alive on April 28, 1971 and that in MY (our) opinion death occurred on the date and hour and from the causes stated above. ID (We) (did) VIEW view the body after death.					
23A. SIGNATURE  M.D.		23B. DATE SIGNED 4/29/71		23C. PHYSICIAN'S NAME (Type) Leonard J. Ruck	
23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 5/1/71		24C. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer Cem,		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 29 1971		25B. NAME OF REGISTRAR Robert E. Faby, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-520 71 4161				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 4161	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) THOMAS, VIRGINIA AUGUSTA				2. DATE AND HOUR OF DEATH APRIL 29, 1971 3:15A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 21229			
FULL NAME OF HOSPITAL OR INSTITUTION 40		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION ST AGNES HOSPITAL WILKENS & CATON AVENUE BALTIMORE, MARYLAND 21229		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 03 05 99	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 72		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA				12. CITIZEN OF WHAT COUNTRY USA			
13. FATHER'S NAME JOHN HENRY X SAUVAGEOT				14. MOTHER'S MAIDEN NAME (HAYES) MARGARET			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO.		17. INFORMANT RECORD'S BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ca of pancreas with disseminated carcinomatosis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from APRIL 15, 1971 to APRIL 29, 1971 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on APRIL 29, 1971 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (<input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.							
23A. SIGNATURE <i>M. Rustia</i>				23B. DATE SIGNED 04 29 71		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) MARY ANN RUSTIA, M.D.				23D. ADDRESS BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5/1/71		24C. NAME of CEMETERY or CREMATORY MT. OLIVET CEMETERY		24D. LOCATION (City, town, or county) (State) WHEELING, W. VA.	
25A. DATE REC'D BY HEALTH DEPT. APR 29 1971		25B. NAME OF REGISTRAR Robert E. Valley, M.D.		25C. FUNERAL DIRECTOR LEONARD J. RUCK INC. BALTO. MD.			

STATE OF ALABAMA

IN SENATE
JANUARY 10, 1901

REPORT

OF THE
COMMISSIONER OF THE
LAND OFFICE

FOR THE YEAR
1900

ALBANY, N.Y.

(HAYES)

ST. AGNES HOSPITAL, ALBANY, N.Y.

REPORT

1901

APRIL 19, 1901

REPORT

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II

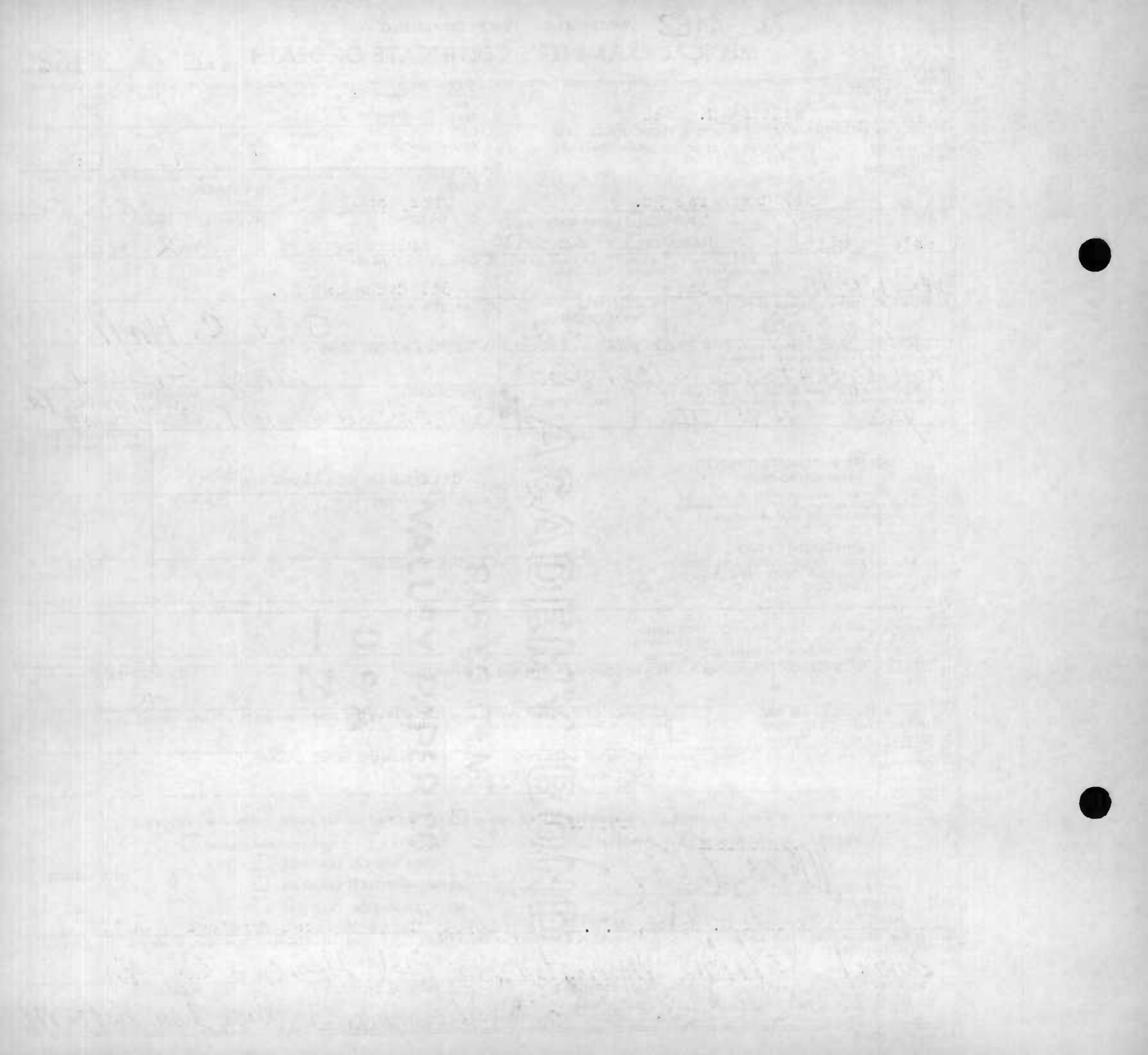
VI

ST. AGNES HOSPITAL, ALBANY, N.Y.

MARY J. RUSTIN, A.D.

H-400 71 4162 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 4162

1. NAME OF DECEASED (Type or Print) William C. Hall		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 4 28 71 10:00 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 517 Cathedral St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 28 71 10:00 a.m.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH DEC. 1, 1915		10. AGE (In years last birthday) 55 58	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roll Operator		14B. KIND OF BUSINESS OR INDUSTRY STEEL CO.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES W W II		17. SOCIAL SECURITY NO.	
18. INFORMANT SUTHERLAND BROWN FUNERAL HOME		ADDRESS Hammond VA.	
19. CAUSE OF DEATH 671.19		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cirrhosis of liver		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)	
20A. DATE OF OPERATION 5/1/71		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE OF EXAMINER'S NAME (Type) Werner H. Spitz, M.D.		DATE SIGNED 4/28/71	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5/1/71	
24C. NAME OF CEMETERY or CREMATORY WASHINGTON MEM. PARK		24D. LOCATION (City, town, or county) (State) Henrico Co. VA.	
25A. DATE REC'D BY HEALTH DEPT. APR 29 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR LEONARD J. RUCK, INC. BALTO. MD.		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4163	
BIRTH NO. M-635 71 4163		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MARTIN, JULIA E.			2. DATE AND HOUR OF DEATH 4-28-71 11:20 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) North Charles General Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2741 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3517 Rose Kemp Avenue		
5. SEX Female		6. RACE Caucasian		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY Homemaker		8. DATE OF BIRTH 12/28/00	
15. FATHER'S NAME James Staples		14. MOTHER'S MAIDEN NAME Dora Schultz		9. AGE (In years last birthday) 70 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
16. SOCIAL SECURITY NO. 218011841		17. INFORMANT Mr. Kenneth R. Bartleson ADDRESS 5205 Larlin Rd.			
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last </div> <div style="width: 35%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 60%;"> (A) IMMEDIATE CAUSE Acute myo infarct DUE TO, OR AS A CONSEQUENCE OF: </div> <div style="width: 35%;"> 20 yrs </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 60%;"> (B) Coronary Art. Disease DUE TO, OR AS A CONSEQUENCE OF: </div> <div style="width: 35%;"> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 60%;"> (C) </div> <div style="width: 35%;"> </div> </div>					



71 4164 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

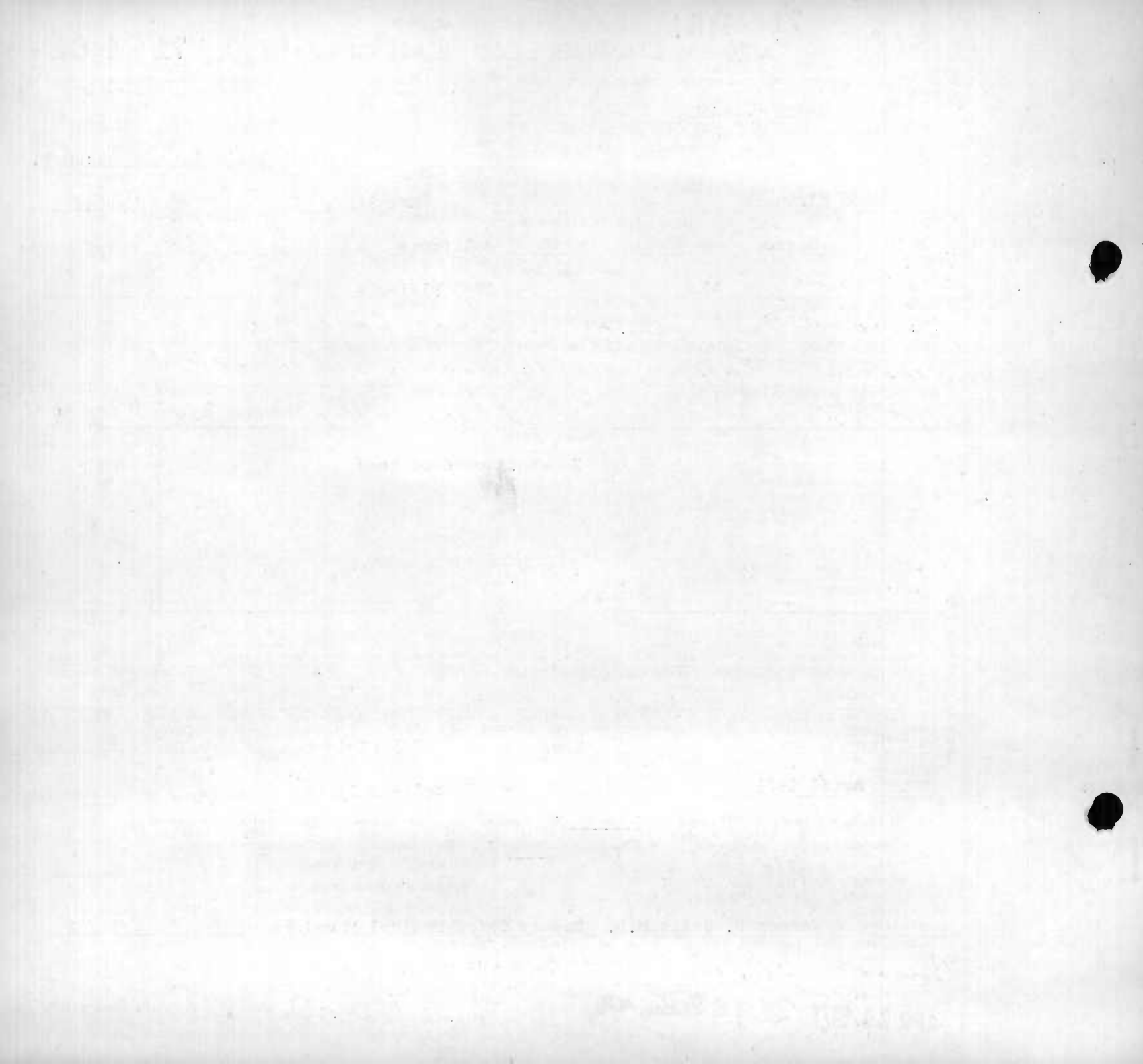
REG. NO. 71 4164

C-636

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FOSTER R. CARTER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M. 3. DATE PRONOUNCED DEAD Month Day Year Hour April 29, 1971 8:20 PM	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) DD 2805 Elsinore		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1538	
6. SEX Male	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH 4-18-1930		10. AGE (In years last birthday) 41 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) BALTO MD		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer CHEMICAL WORKS		15. MOTHER'S MAIDEN NAME NANNIE V. JOHNSON	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes Korean		17. SOCIAL SECURITY NO. ELIZABETH HENDERSON 3506 WOODBURN AVE	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gunshot wound of head (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 2805 Elsinore 1538		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22D. TIME OF INJURY (Approx.) April 1971		22F. HOW DID INJURY OCCUR? Self-inflicted	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/30/71 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/30/71	
24C. NAME OF CEMETERY or CREMATORY MT AUBURN		24D. LOCATION (City, town, or county) (State) BALTO MD	
25A. DATE REC'D BY HEALTH DEPT. APR 29 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Franklin & Sons 638 N. Green St		ADDRESS	

VS 151-REV. 1/1/68



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4165	
4-635		71 4165		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Nettie Howerton		2. DATE AND HOUR OF DEATH April 25 1971 5:10 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md B. COUNTY Balto		C. CITY OR TOWN Balto	
FULL NAME OF HOSPITAL OR INSTITUTION HARBOR View Light St 90		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE N		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 12/25/24		9. AGE (in years last birthday) 46		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMSTRESS	
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Edward Jones	
14. MOTHER'S MAIDEN NAME Smith		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Lillian Jones		ADDRESS 755 Lexington		18. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of Lung Metastasis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 71 4165	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/26 1971 to 4/25 1971 that (I) (we) last saw the deceased alive on 4/18 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph S. Blum		23B. DATE SIGNED 4/22/71		23C. PHYSICIAN'S NAME (Type) JOSEPH S. BLUM MD	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4-30-71		24C. NAME of CEMETERY or CREMATORY Arbutus Mem. PK.	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT. APR 29 1971		24F. NAME OF REGISTRAR Robert E. Taylor	
24G. FUNERAL DIRECTOR V.R. Bailey		24H. ADDRESS 1348 Calhoun		24I. DATE REC'D BY HEALTH DEPT. APR 29 1971	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 4166		REG. NO. 71 4166	
CERTIFICATE OF DEATH							
BIRTH NO. H-300		71 4166		1. NAME OF DECEASED (Type or Print) LAVINIA B. HEATH		2. DATE AND HOUR OF DEATH 4-27-71 7:55 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Lutheran Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 1502			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital				C. CITY OR TOWN BALTO.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1520 N. APPLETON ST.			
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-8-89	9. AGE (in years lost birthday) 81	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME Rose Fountain			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 216-54-5192		17. INFORMANT Lillian Johnson	
				ADDRESS 1520 Appleton St.			
18. CAUSE OF DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiogenic shock				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASHD				(B) DUE TO, OR AS A CONSEQUENCE OF: senility		(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 6		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/27/71 to 4/27/71 and that (I) (we) lost saw the deceased alive on 4/27/71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Jorge A. Bello				23B. DATE SIGNED 4/27/71		23C. PHYSICIAN'S NAME (Type) Jorge A. Bello	
23D. ADDRESS Lutheran Hosp. ER				23E. DATE SIGNED 4/27/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/1/71		24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 29 1971		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR Kelson F.H.			
				ADDRESS 1348 N. Calhoun St.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 4167	
H-230 71 4167				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MARY HACKETT		April 27, 1971 2:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
MARYLAND GENERAL 48 HOSPITAL			MARYLAND 1301		
C. CITY OR TOWN			D. INSIDE CITY LIMITS?		
BALTIMORE			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER			2509 MADISON AVE		
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
FEMALE		NEGRO		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
				06/14/89	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		9. AGE (In years last birthday)	
MARYLAND		USA		82	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
No					Helen Hackett 2509 Madison Ave.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES				PNEUMONIA	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last				(B) CRANIOCENTE LEFT FOOT	
(C) ASCVD				DUE TO, OR AS A CONSEQUENCE OF:	
II				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				DAYS	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
4/20/71		CRANIOCENTE		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 4/18/71 19 to 4/27 1971 that (I) (we) last saw the deceased alive on 4/27/71 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Charles M. Harrison MD				4/27/71	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
CHARLES M. HARRISON MD				Maryland General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		5/1/71		Arbutus Mem. Park	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 29 1971		Robert E. Taylor, R.D.		Kelson F.H. 1348 N. Calhoun St.	

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Harold Harriday				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 39 PROVIDENT HOSPITAL				3. DATE PRONOUNCED DEAD Month Day Year Hour April 26, 1971 7:00 P.M.			
6. SEX Male				7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Mar. 8, 1963				10. AGE (In years lost birthday) 8		11. BIRTHPLACE (State or foreign country) Md.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Mary Harriday	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Marcella Hurd 2927 Violet Ave.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Craniocerebral Injuries				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Private Driveway			
22D. TIME OF INJURY (APPROX.) 4-26-71 6:30 P.M.				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Rear 3704 Overview Rd. North of Violet Ave.				22F. HOW DID INJURY OCCUR? Subject fell from moving truck			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 4/30/71		24C. NAME OF CEMETERY or CREMATORY Ames Cem.	
24D. LOCATION (City, town, or county) (State) Falston, Maryland				25A. DATE REC'D BY HEALTH DEPT. APR 29 1971			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.				25C. FUNERAL DIRECTOR ADDRESS Kelson F.H. 1348 N. Calhoun St.			

WALLACE FORMS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 4169

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Gertrude McCray

2. DATE
OF
DEATHKnown ☒Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

2841

6. SEX

female

7. RACE

colored

B. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

Mar. 4, 1913

10. AGE (In years
lost birthday)

58

If Under 1 Yr. If Under 24 Hrs.
Months, Days, Hours, Min.

E. STREET AND NUMBER

5622 Cadillac Ave.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF

WHAT COUNTRY?
USA

13. FATHER'S NAME

James Hutchins

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Mary Smith

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or doles of service)

No

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Ernest McCray 5622 Cadillac Ave.

19. 174X

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Carcinoma of breast with metastases
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

Deputy Chief Medical Examiner

DATE SIGNED

4/28/71

24A. BURIAL CREMATION,
REMOVAL (Specify)
Burial

24B. DATE

May 1, 1971

24C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cem.

24D. LOCATION (City, town, or county) (State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT

APR 29 1971

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Kelson F.H. 1348 N. Calhoun St.

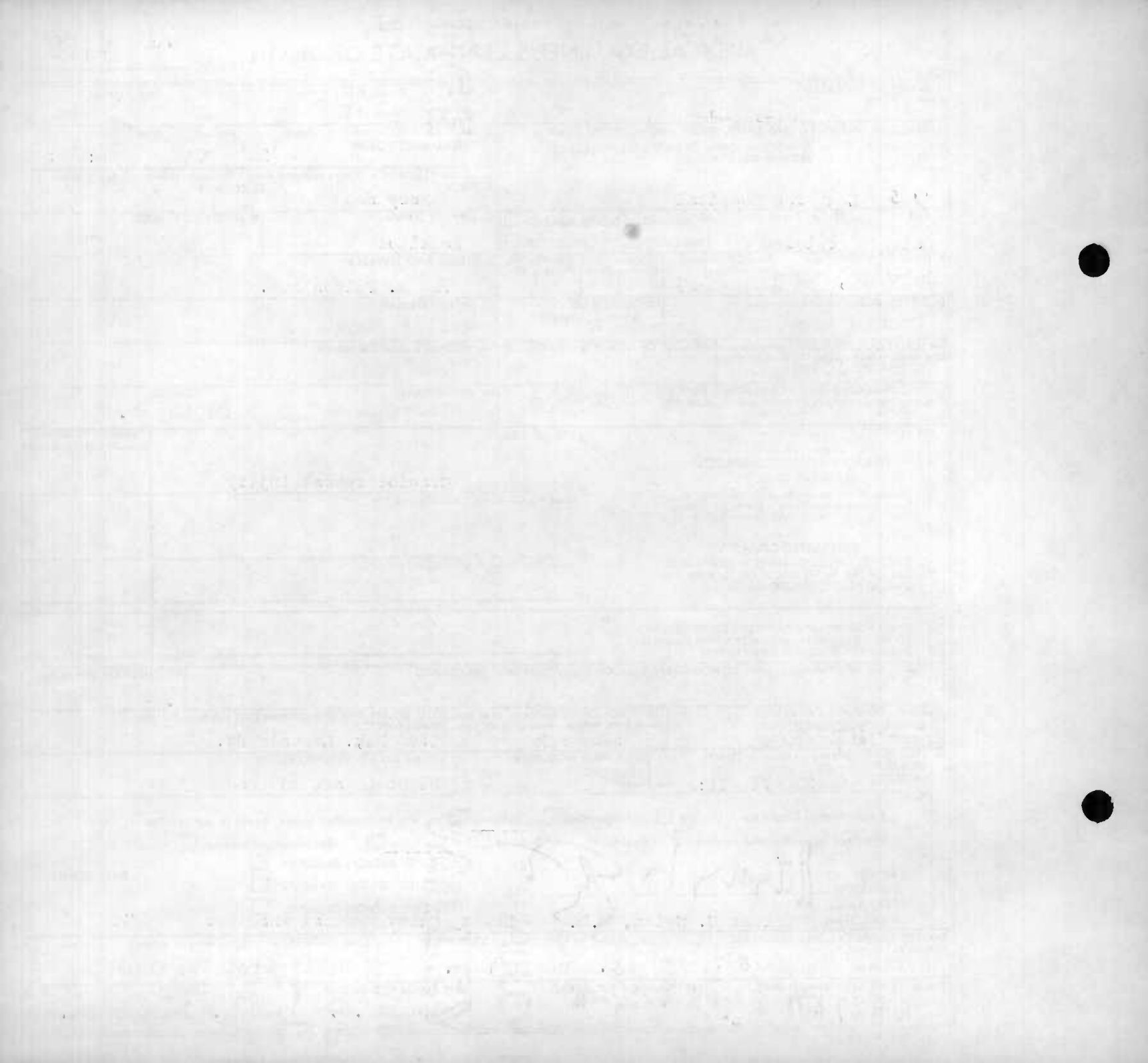
V. ADDRESS

ACADEMY & BOND

WILLIAM PATTEN CO.

U.S.A.

BALTIMORE CITY HEALTH DEPARTMENT				71 4170			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				71 4170			
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) Henry Rose				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 Lutheran Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour 4 24 71 9:00 a M.			
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1604				C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
6. SEX male		7. RACE colored		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 734 N. Fulton Ave.	
9. DATE OF BIRTH July 30, 1923		10. AGE (In years last birthday) 47		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Willie Rose				14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction			
15. MOTHER'S MAIDEN NAME Rena Mouzon				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, never unknown) (If yes, give war or dates of service) yes WW II			
17. SOCIAL SECURITY NO. 230-22-9638				18. INFORMANT ADDRESS Gladys Rose 2209 Booth St.			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E 965X (A) IMMEDIATE CAUSE Craniocerebral injury DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) yes				22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) sidewalk				22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 1700 Blk. Lanvale St. 1603			
22D. TIME OF INJURY (APPROX.) 4 23 71 11:30pm				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			
22F. HOW DID INJURY OCCUR? blunt impact to head				23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL EXAMINER'S NAME (Type) Werner U. Spitz, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner 4/25/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 4/28/71			
24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT APR 29 1971				25B. NAME OF REGISTRAR Robert E. Taylor, M.D.			
25C. FUNERAL DIRECTOR Kelson F.H.				25D. ADDRESS 1348 N. Calhoun St.			



A-163

71 4171

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 4171

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ELISHA ROBERTSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1105 N. Calhoun Street		3. DATE PRONOUNCED DEAD Month Day Year Hour April 27, 1971 7:30 A.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH May 15, 1891		10. AGE (In years last birthday) 80 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Jennie Nance		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Unk.	
17. SOCIAL SECURITY NO. 251-38-0753		18. INFORMANT ADDRESS Roxie House 2919 W. Mosher St.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/27/71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/2/71	
24C. NAME OF CEMETERY or CREMATORY Mt. Zion Church Cem.		24D. LOCATION (City, town, or county) (State) Laurens, South Carolina	
25A. DATE REC'D BY HEALTH DEPT. APR 29 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Kelson F.H.		25D. ADDRESS 1348 N. Calhoun St.	

WALLACE & GROMMET
WALLACE & GROMMET
WALLACE & GROMMET

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

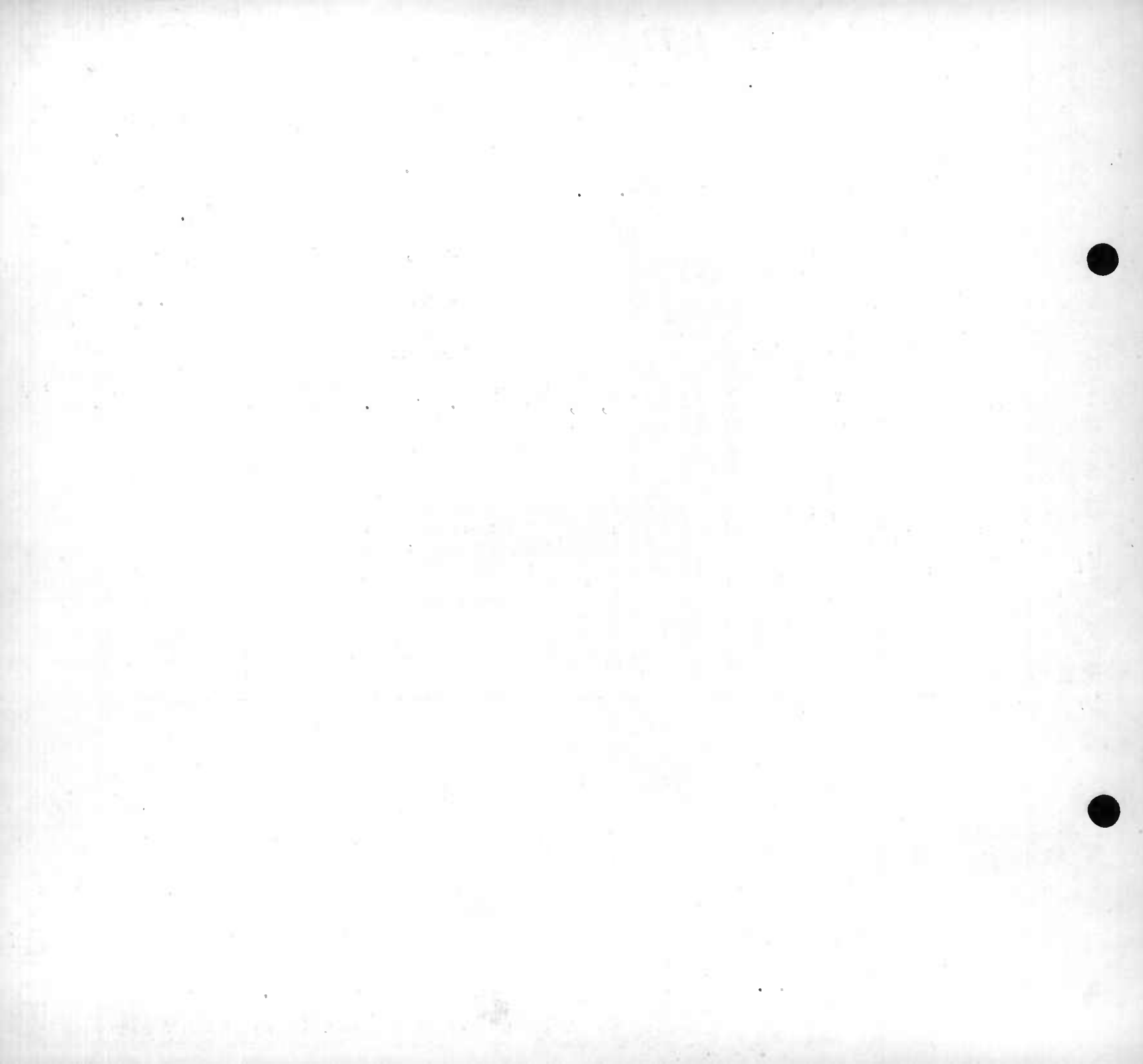
BALTIMORE CITY HEALTH DEPARTMENT				71 4172	
CERTIFICATE OF DEATH				REG. NO. 71 4172	
0-540 71 4172 BIRTH NO. 11-07114		1. NAME OF DECEASED (Type or Print) BABY BOY O'NEIL		2. DATE AND HOUR OF DEATH 4/28/71 12:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY HOSPITAL 38			A. STATE MD B. COUNTY 2505		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1509 Elmtree St.		
5. SEX M	6. RACE CAUC.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/25/71	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months Days 2
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) BALTIMORE		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME ROBERT O'NEIL			14. MOTHER'S MAIDEN NAME MOLLIE BOGGS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	17. INFORMANT PL. CHART		
18. 730.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (1A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIOPULMONARY ARREST (B) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF: (C) TRACHEO-ESOPHAGEAL FISTULA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 DAYS BIRTH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 4/26/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED TE FISTULA		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 4/25 19 71 to 4/28 19 71 that (1) (we) last saw the deceased alive on 4/28 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sharon Satterfield				23B. DATE SIGNED 4/28/71	
23C. PHYSICIAN'S NAME (Type) SHARON SATTERFIELD				23D. ADDRESS UNIVERSITY HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/1/71		24C. NAME OF CEMETERY OR CREMATORY Cedar Hill	
24D. LOCATION Ritchie Hwy Balto d.		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. APR 29 1971		25B. NAME OF FUNERAL DIRECTOR McCully		25C. FUNERAL DIRECTOR ADDRESS 237 Patapsco Ave 21225	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

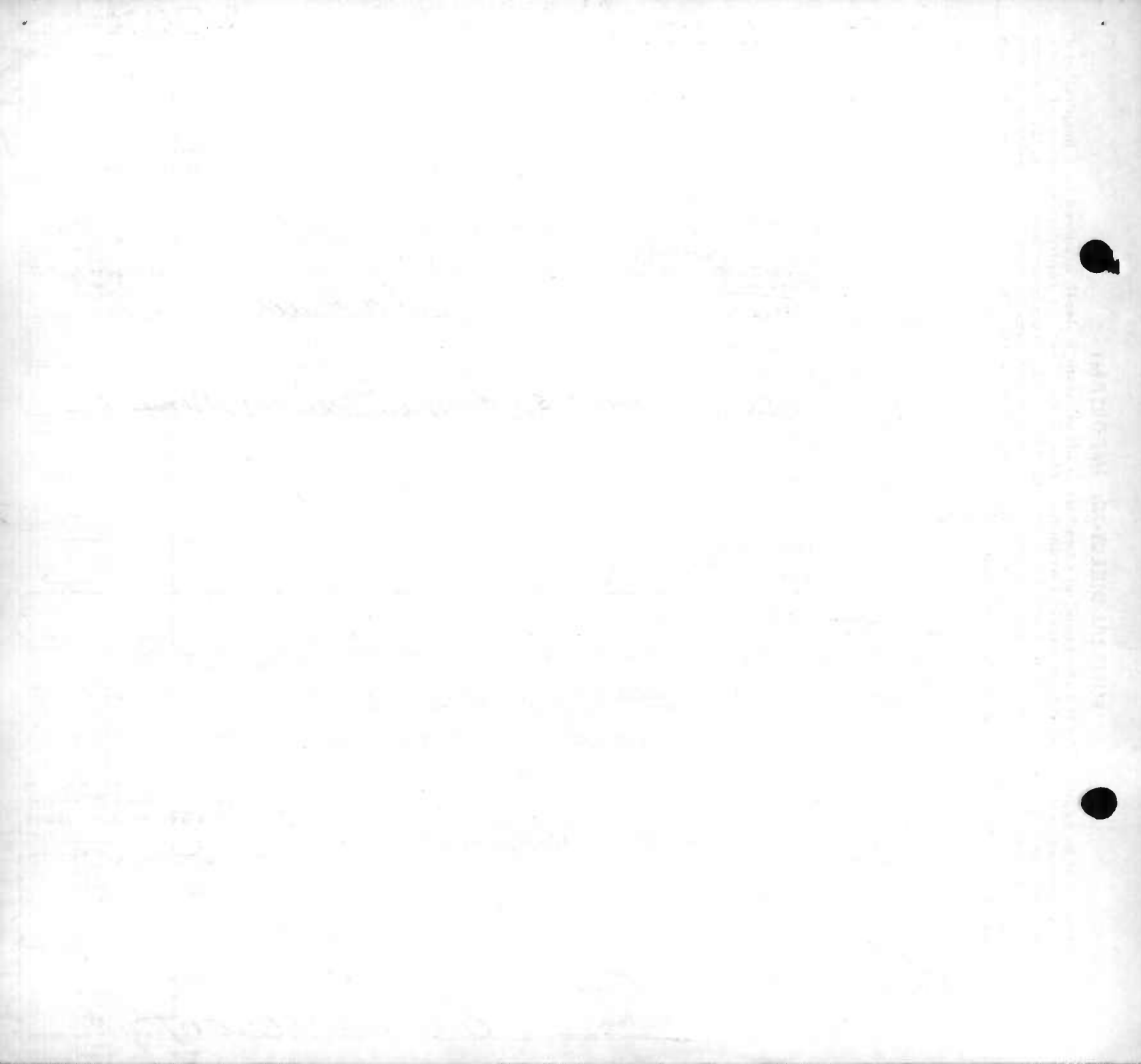
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	71 4173
L-522 71 4173		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Ella M. Lancaster</i>		2. DATE AND HOUR OF DEATH <i>April 28 1971</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>4006 3rd Street Balto. Md.</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>BALTO.</i> C. CITY OR TOWN <i>alto. Md</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>4006 3rd Street Balto Md. 2534</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 20, 1902</i>	9. AGE (In years last birthday) <i>69</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country) <i>Penna</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		13. FATHER'S NAME <i>John A Stoltenberg</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>217,50,8014</i>		17. INFORMANT <i>Mrs. Ella M. Briley 4006 3rd St Balto Md</i>	
18. <i>410.91</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>myocardial infarction</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) <i>arteriosclerosis severe diabetes</i> DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Jan. 1959</i> to <i>April 27 1971</i> , that (I) (we) last saw the deceased alive on <i>April 20 1971</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE <i>Eugene Schnitzer</i>		23B. DATE SIGNED <i>4-29-71</i>		23C. PHYSICIAN'S NAME (Type) <i>EUGENE SCHNITZER M.D.</i>	
23D. ADDRESS <i>3904 S. Hanover St. Balto. Md.</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5.1.71</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Meadowridge Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Dorsey Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>APR 29 1971</i>		25B. NAME OF REGISTRAR <i>John E. Fisher, Jr.</i>		25C. FUNERAL DIRECTOR <i>McCully Funeral Home</i>	
25D. ADDRESS <i>237 Patapsco Ave</i>					



FUNERAL DIRECTOR: IMPORTANT

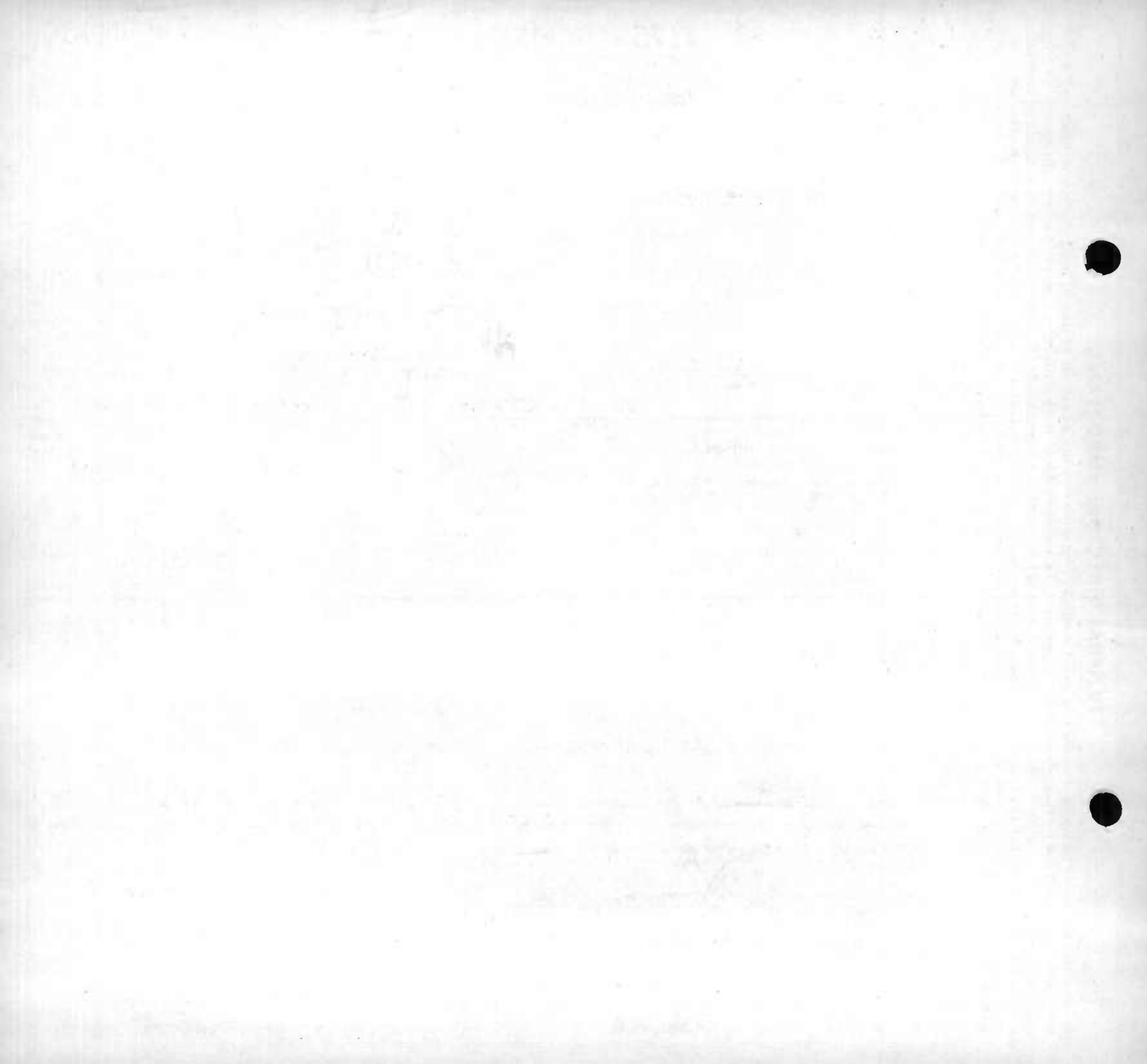
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 71 4174				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 4174	
1. NAME OF DECEASED (Type or Print) McMillian Alex				2. DATE AND HOUR OF DEATH 4/28/71 1 10 A. M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 704					
FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER 1512 Ashland Avenue					
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/22/07	9. AGE (In years last birthday) 63	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lee McMillian				14. MOTHER'S MAIDEN NAME Fannie Welch					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service Yes				16. SOCIAL SECURITY NO. 244-05-0528		17. INFORMANT Fannie Welch ADDRESS 4100 Manne Rd			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 486X/1X-303.2				CAUSE OF DEATH (A) IMMEDIATE CAUSE Pneumonia DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) chronic alcoholism					
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from April 6 19 71 to April 28 19 71 that (X) (we) lost saw the deceased alive on April 28 19 71 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.									
23A. SIGNATURE A. R. Austin, M.D.				23B. DATE SIGNED 4/28/71				23C. PHYSICIAN'S NAME (Type) S. R. Austin, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 5-3-71		24C. NAME OF CEMETERY or CREMATORY not known		24D. LOCATION (City, town, or county) (State) Balto Md	
25A. DATE REC'D BY HEALTH DEPT. APR 29 1971				25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Edw. L. Brown ADDRESS 2000 B. Street			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-642		71 4175		CERTIFICATE OF DEATH		REG. NO. 71 4175	
1. NAME OF DECEASED (Type or Print) Minty Elizabeth Charles				2. DATE AND HOUR OF DEATH April 26, 1971 11:10 p.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3413 Piedmont Avenue				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1538 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3413 Piedmont Avenue			
5. SEX Female	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-28-1913	9. AGE (In years last birthday) 58	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY Pvt. Family		11. BIRTHPLACE (State or foreign country) Magnolia, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jerry Gilbert				14. MOTHER'S MAIDEN NAME Ossie Johnson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 800-02-2677		17. INFORMANT ADDRESS Mr. Elbert Charles 3413 Piedmont Ave.			
18. 4-12-21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cardiac Arrest ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hypertensive arteriosclerotic Cardiovascular Disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 approx. minutes			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Nov 20 1965 to April 26 1971 , that (I) (was) last saw the deceased alive on April 26 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death.							
23A. SIGNATURE Samuel V. Tompakov				23B. DATE SIGNED 4-28-71		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) Samuel V. Tompakov M.D.				23D. ADDRESS 7211 Park Heights Avenue			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-1-1971		24C. NAME of CEMETERY or CREMATORY Family Lot		24D. LOCATION (City, town, or county) (State) Harford Co. Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 29 1971		25B. NAME OF REGISTRAR R. E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS NUTTER FUNERAL HOME 3035 W. NORTH AVE			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4176	
BIRTH NO. 71 4176		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) RICHARD BOWSER		2. DATE AND HOUR OF DEATH 4-28-71 4:30 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital, Inc. 2600 Liberty Heights Ave. Baltimore, Maryland 21215		A. STATE Maryland B. COUNTY 1503			
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 2345 W. North Avenue			
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-23-1896	9. AGE (In years last birthday) 75
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Counselor		10B. KIND OF BUSINESS OR INDUSTRY Central YWCA		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME George Bowser			
14. MOTHER'S MAIDEN NAME Agnes Quinn		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes World War I			
16. SOCIAL SECURITY NO. 212-30-0572		17. INFORMANT ADDRESS Mrs. Maggie Bowser 2345 W. North Avenue			
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE Uremia with Chronic Renal Failure DUE TO, OR AS A CONSEQUENCE OF: (B) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF: (C) Arteriosclerotic Heart Disease			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Intraabdominal malignancy					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 16, 19 71 to April 28, 19 71 that (I) (we) last saw the deceased alive on April 28, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Elijah Saunders</i> M.D. DEGREE				23B. DATE SIGNED 4-28-71	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS ELIJAH SAUNDERS, M. D. DEGREE 2600 Liberty Heights Ave. Balto., Md. 21215			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-1-1971		24C. NAME of CEMETERY or CREMATORY Mt Auburn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. APR 29 1971			
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS NUTTER FUNERAL HOME 3035 W. NORTH AVE			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

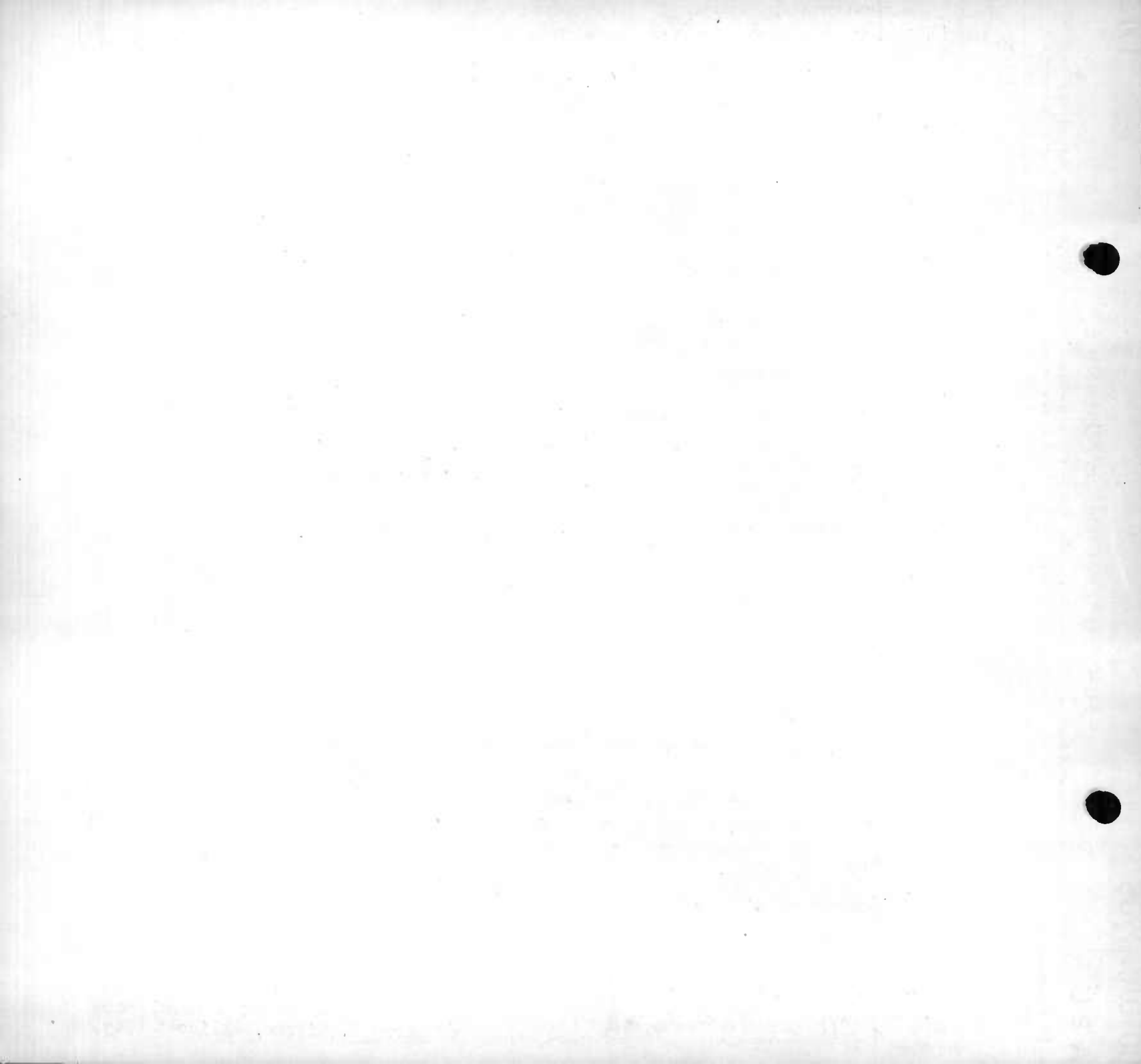
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4177	
CERTIFICATE OF DEATH					
BIRTH NO. R-200 71 4177					
1. NAME OF DECEASED (Type or Print) Elsie Mae Rice		2. DATE AND HOUR OF DEATH 4/28/71 8:55P			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 148 Palmora Ave		A. STATE Md. B. COUNTY Balto.			
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 148 Palmora Ave.			
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/29/1894	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Browning		14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Rte 2 Roberta Long Mt. Airy, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 2009 I 1 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH Coronary Thrombosis left side Arteriosclerosis (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: H C U S E (B) DUE TO, OR AS A CONSEQUENCE OF: Diabetes Mellitus Insulin (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 4 years 4 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 8/16 19 66 to 4/29 19 71 that (I) (we) last saw the deceased alive on 4/26 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Elliott Johnson		23B. DATE SIGNED 4/29/71		23C. PHYSICIAN'S NAME (Type) Dr. Elliott Johnson	
23D. ADDRESS 3432 Frederick Ave.		23E. CITY, TOWN, OR COUNTY Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/1/71		24C. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	
24D. LOCATION Baltimore, Maryland		24E. STATE Maryland			
25A. DATE REC'D BY HEALTH DEPT. APR 29 1971		25B. NAME OF REGISTRAR R. E. Johnson, M.D.		25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Ave., 21228	

Palermo Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

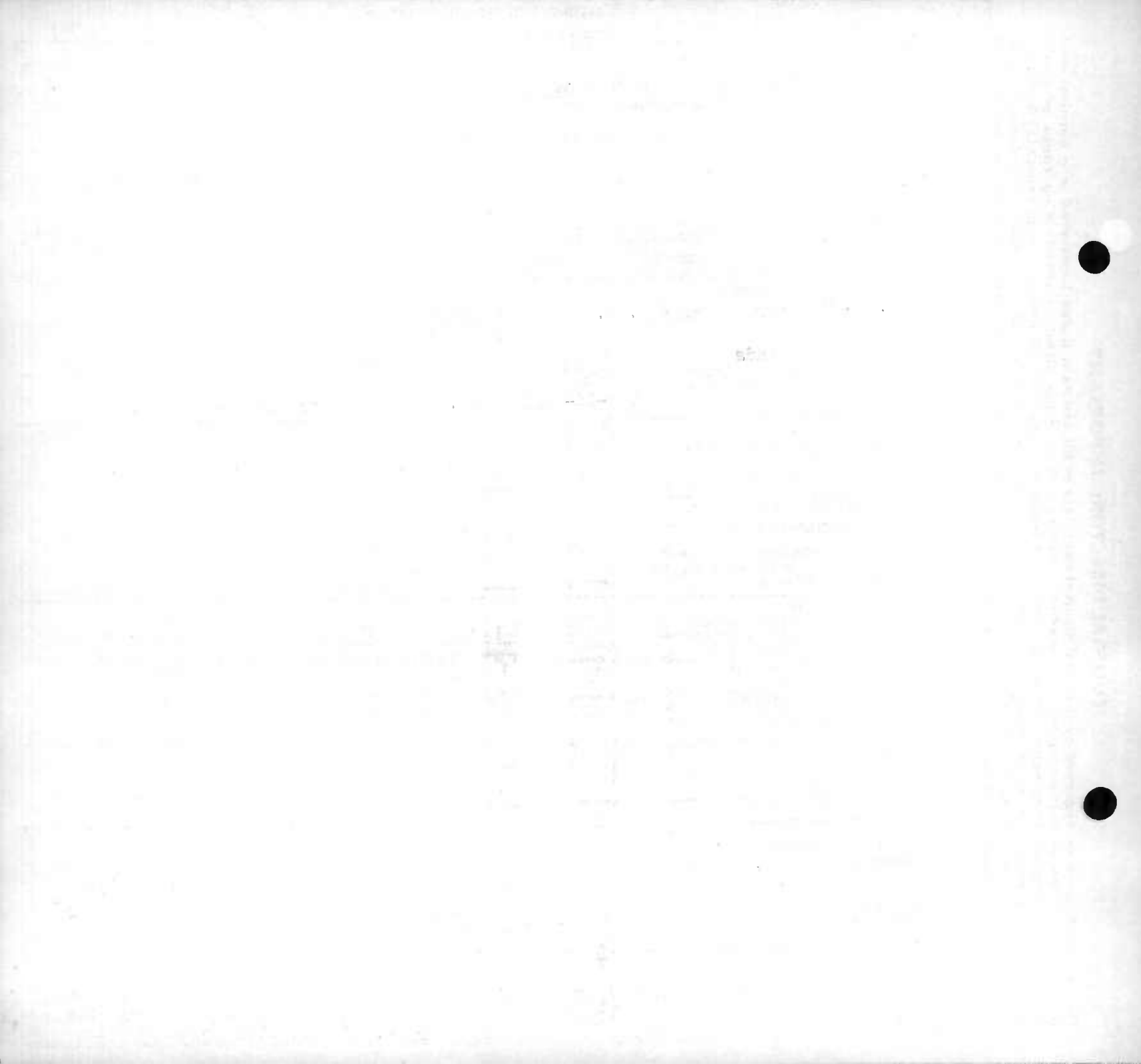
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 4178	
W-220 71 4178		BIRTH NO.	
1. NAME OF DECEASED (Type or Print) Alovsius (al) Wahoskoffie (Wachoski)		2. DATE AND HOUR OF DEATH 4/23/71 5 45 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD The Gould Convalescencium		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Pratt St. Maryland 105	
FULL NAME OF HOSPITAL OR INSTITUTION The Gould Convalescencium		C. CITY OR TOWN Baltimore	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 2112 Pratt Sr.			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 01-01-03
9. AGE (In years lost birthday) 68		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-18-0101	
17. INFORMANT REC'D GOULD CONVALLARIUM		ADDRESS	
18. 412.31 + 019.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Heart Disease (B) Generalized Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Emphysema, Old Tuberculosis, Congestive Heart Failure			
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN IDENTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/30/71 to 4/23/71 , that (I) (we) last saw the deceased alive on 4/22/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE Albert B. Bradley		23B. DATE SIGNED 4/23/71	
23C. PHYSICIAN'S NAME (Type) Albert B. Bradley		23D. ADDRESS 4900 Belair Road	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/29/71	
24C. NAME OF CEMETERY or CREMATORY GETTYSBURG NATL CEMETERY		24D. LOCATION (City, town, or county) (State) GETTYSBURG, PENNA.	
25A. DATE REC'D BY HEALTH DEPT. APR 29 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Howard Cty Funeral Home		ADDRESS of Harry H. Witzke, Ellicott City, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. <u>71 4179</u>	
BIRTH NO. <u>R-320</u> <u>71 4179</u>		CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <u>HARRY D. RHODDS</u>				2. DATE AND HOUR OF DEATH <u>April 28, 1971</u> <u>1:50 P. M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>JOHNS HOPKINS HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>HOWARD</u> C. CITY OR TOWN <u>COLUMBIA</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>218 CONCORD HOUSE</u>			
5. SEX <u>M</u>	6. RACE <u>CAUCASIAN</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/29/00</u>	9. AGE (In years lost birthday) <u>70</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Office Mgr</u>	11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Late Orville Rhoads</u>			14. MOTHER'S MAIDEN NAME <u>Late Emma</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 			16. SOCIAL SECURITY NO. <u>716-16-9024</u>		17. INFORMANT ADDRESS <u>Mrs. Missie Rhoads, 218 Concord House</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <u>Septic Cerebrovascular Accident</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Diffuse arteriosclerotic cerebrovascular disease DUE TO, OR AS A CONSEQUENCE OF: (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>years</u> <u>5 years</u>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Diabetes mellitus</u>							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>April 15</u> 19 <u>71</u> to <u>April 28</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>April 28</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Robert A. Adler MD</u>				23B. DATE SIGNED <u>4/28/71</u>		23C. PHYSICIAN'S NAME (Type) <u>ROBERT A. ADLER</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>5/1/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Grace Lawn Memorial</u>	
24D. LOCATION (City, town, or county) (State) <u>Wilmington, Delaware</u>				25A. DATE REC'D BY HEALTH DEPT. <u>APR 29 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Jaber, MD.</u>				25C. FUNERAL DIRECTOR ADDRESS <u>Howard County Funeral Home of Harry H. Witzke, 4112 Columbia Pike</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 4180	
CERTIFICATE OF DEATH				REG. NO. 71 4180	
1. NAME OF DECEASED (Type or Print) <u>YEARBY, Willie</u>		2. DATE AND HOUR OF DEATH <u>April 24, 1971</u> <u>11:00 P.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Bolton Hill Nursing Home</u> <u>1600 JOHN ST. BALTIMORE</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>469 Oxford Street</u>			
5. SEX <u>M</u>	6. RACE <u>Black</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/18/87</u>	9. AGE (in years last birthday) <u>83</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fisherman Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>William Verby</u>		14. MOTHER'S MAIDEN NAME <u>Dorice Walters</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-01-2170</u>		17. INFORMANT <u>Admission Record</u>	
18. <u>150X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinoma of Esophagus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <u>April 5</u> 19 <u>71</u> to <u>April 25</u> 19 <u>71</u> that (H) (we) last saw the deceased alive on <u>April 25</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Peter H. Rheinstein, MD</u>		23B. DATE SIGNED <u>25 April 1971</u>		23C. PHYSICIAN'S NAME (Type) <u>PETER H. RHEINSTEIN, MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/29/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Wt. Cullum Cem.</u>	
24D. LOCATION <u>Balto. Md.</u>		24E. LOCATION (City, town, or county) (State)		24F. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 29 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>Williams Funeral Home</u>	
25D. ADDRESS <u>319 N. Schroeder St.</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 4181</u>	
BIRTH NO. <u>R-152</u>		71 4181		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Robinson, Clarence</u>			2. DATE AND HOUR OF DEATH <u>4/27/71</u> <u>6 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>md.</u> B. COUNTY <u>1801</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>George Washington Nursing Home</u> <u>607 Pennsylvania ave</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>Male</u>			6. RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Post Black</u>			8. DATE OF BIRTH <u>10/13/95</u>		9. AGE (In years, last birthday) <u>75</u>
10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Robinson, Charles</u>			14. MOTHER'S MAIDEN NAME <u>NANNIE BONNETT</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u>			16. SOCIAL SECURITY NO. <u>215-01-43691</u>		17. INFORMANT <u>Chait</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CARCINOMA OF LUNG WITH METASTASIS</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Feb 71</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>3-26-71</u> to <u>4-27-71</u> and that (1) (we) last saw the deceased alive on <u>4-26-71</u> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Richard L. Tyson, M.D.</u>				23B. DATE SIGNED <u>4-27-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Richard L. Tyson</u>				23D. ADDRESS <u>920 W. North Ave</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/1/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>W. Nelson Cem.</u>	
24D. LOCATION <u>Balt. Md.</u>		24E. NAME OF REGISTRAR <u>APR 28 1971</u>		25C. FUNERAL DIRECTOR <u>Williams Funeral Home</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 28 1971</u>		25B. NAME OF REGISTRAR <u>Williams Funeral Home</u>		ADDRESS <u>319 S. ...</u>	

B650

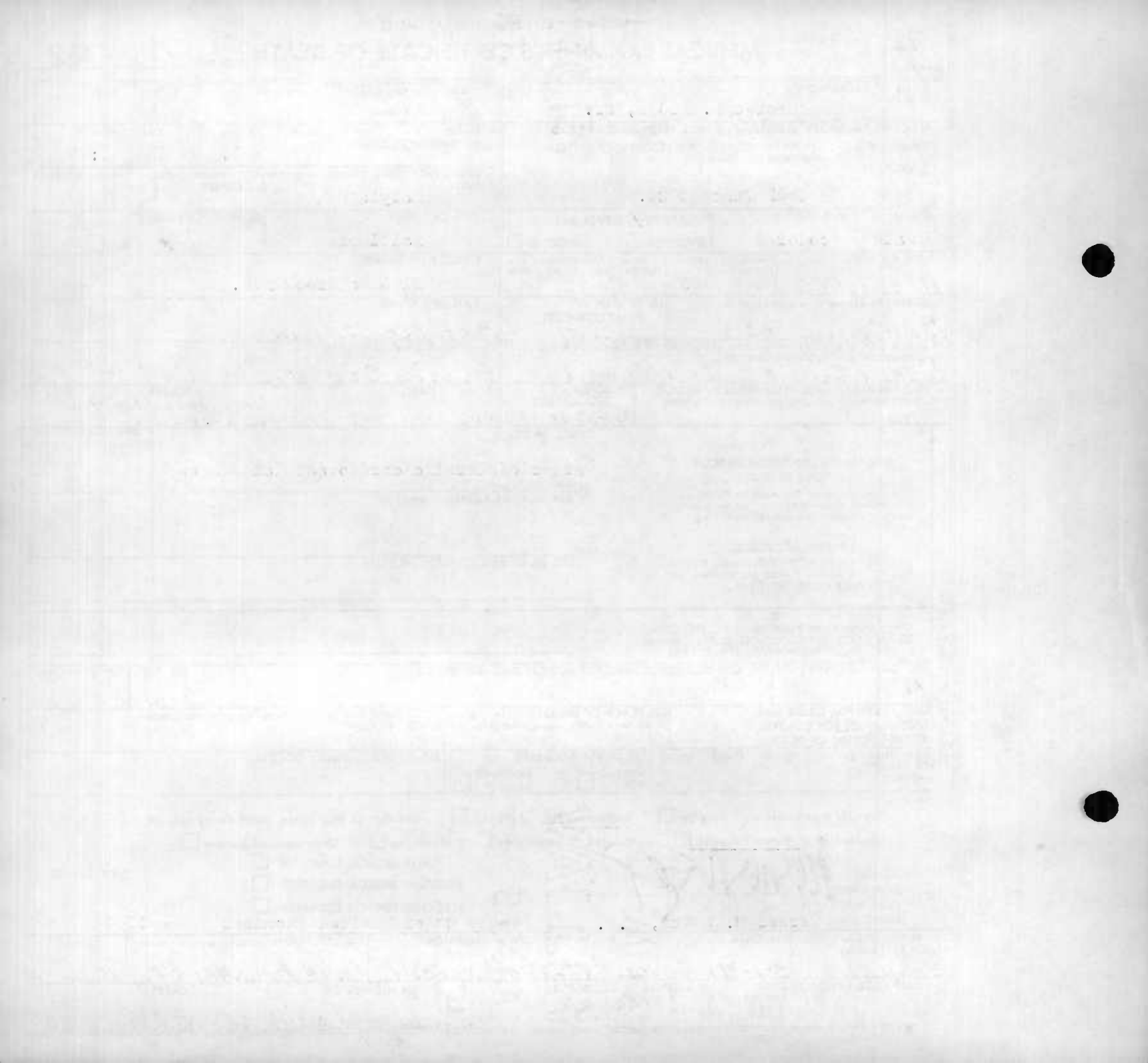
71 4182

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 4182

BIRTH NO.		1. NAME OF DECEASED (Type or Print) George D. Brown, Sr.		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1602 Vincent Ct.		3. DATE PRONOUNCED DEAD Month Day Year 4 27 71 1:40 p M.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1506	
6. SEX male	7. RACE colored	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 11-30-1905		10. AGE (In years last birthday) 65		E. STREET AND NUMBER 3106 Walbrook Ave.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Ambrose Brown	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Livery Service		14B. KIND OF BUSINESS OR INDUSTRY Self Employed		15. MOTHER'S MAIDEN NAME Bessie Strange	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 217-22-1089		18. INFORMANT Mrs. Margaretta Robinson Brown	
19. 4182.4		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) NO	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/27/71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-1-71		24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery	
24D. LOCATION (City, town, or county) (State) Anne Arundel Co., Md.		24E. FUNERAL DIRECTOR Raudolph J. Corlick		24F. ADDRESS 2431 E. Oliver St.	
25A. DATE REC'D BY HEALTH DEPT. APR 29 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Raudolph J. Corlick	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

LEONA ~~Debnam~~ ~~DEBLIN~~2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

1403 N. Linwood Avenue

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

April 24, 1971

3:25 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Baltimore

YES ☒NO ☐

6. SEX

Female

7. RACE

Negro

B. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. DATE OF BIRTH

1-28-1935

10. AGE (In years
last birthday)

36

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

28

E. STREET AND NUMBER

1403 N. Linwood Avenue

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Burrell Kennedy

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Domestic

14B. KIND OF BUSINESS OR INDUSTRY

Private

15. MOTHER'S MAIDEN NAME

Helen Reid

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

28-32-2723

18. INFORMANT

ADDRESS

Mrs. Doris Scott 1008 Rutland Ave.

19.

2965X

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Shotgun wound of neck

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Home

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

1403 N. Linwood Avenue

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.) 4-24-71 3:10 A.M.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Shot during altercation

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

Deputy CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/24/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

4-28-71

24C. NAME OF CEMETERY or CREMATORY

Mt. Calvary Cemetery

24D. LOCATION (City, town, or county)

Anne Arundel Co., Md.

25A. DATE REC'D BY HEALTH DEPT.

APR 29 1971

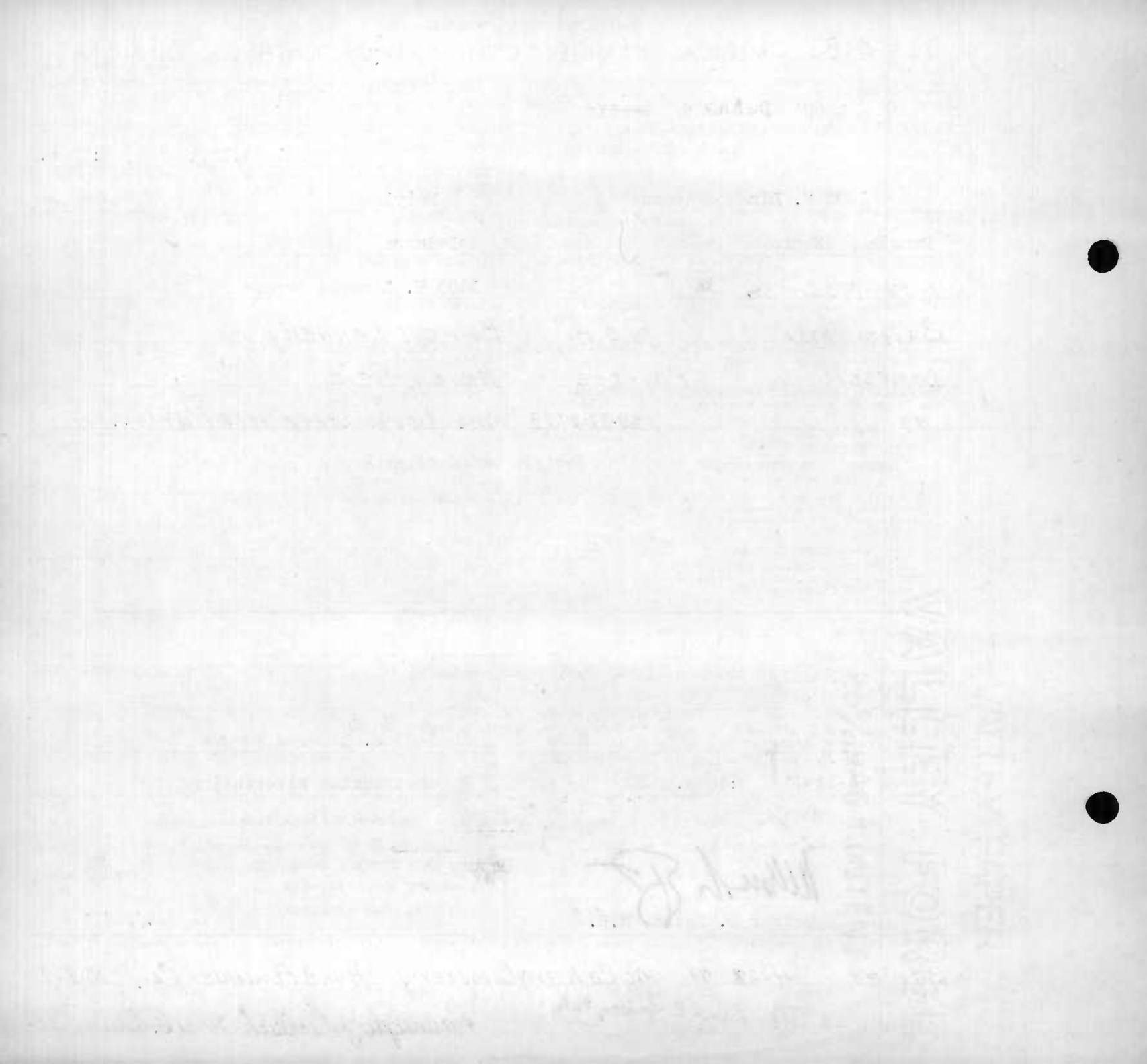
25B. NAME OF REGISTRAR

Robert E. Gable, M.D.

25C. FUNERAL DIRECTOR

Randolph J. Collick 2431 E. Oliver St.

ADDRESS



C 550

71 4184

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 4184

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM H. CUNION, JR.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 001206 N. Milton Street		3. DATE PRONOUNCED DEAD Month Day Year Hour April 22, 1971 5:20 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 5-1-1901		10. AGE (In years lost birthday) 69 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Halifax Co., Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY Ice Co.	
15. MOTHER'S MAIDEN NAME MARY MILLS		15. MOTHER'S MAIDEN NAME MARY MILLS	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 225-07-3821	
18. INFORMANT Mrs. MARY CUNION 1206 N. MILTON AVE		ADDRESS 1206 N. MILTON AVE	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cancer of Stomach		CAUSE OF DEATH Cancer of Stomach	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Isidore Mihalakis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-27-71	
24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery		24D. LOCATION (City, town, or county) (State) Anne Arundel Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 29 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Rudolph J. Ledick		ADDRESS 2431 E. Oliver St.	

1911
2-1-1911
Lafayette
The Co.
Henry Hill
William Cannon
General
The Lafayette County Board of Supervisors
Lafayette, Mo.
Dear Sir:
I have the honor to acknowledge the receipt of your letter of the 28th inst. and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.
Very respectfully,
Your obedient servant,
J. H. [Name]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH				REG. NO. <u>71 4185</u>			
BIRTH NO. <u>71 4185</u>				1. NAME OF DECEASED (Type or Print) BAXTER BOSS				2. DATE AND HOUR OF DEATH <u>4/21/71</u> <u>6¹⁵ P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY 808				C. CITY OR TOWN BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL <u>33</u>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				E. STREET AND NUMBER 1120 Mc DONOUGH ST.			
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 28 95	9. AGE (in years lost birthday) 75	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	12. CITIZEN OF WHAT COUNTRY? U.S.A.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber				10B. KIND OF BUSINESS OR INDUSTRY Self Employed				11. BIRTHPLACE (State or foreign country) Smithfield, Va.			
13. FATHER'S NAME WILLIAM				14. MOTHER'S MAIDEN NAME JERAM Roberts							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 213305868				17. INFORMANT Mrs Elizabeth Boss 1120 Mc Donough St.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Myocardial infarct 6 hrs				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD 10-20 yrs				(B) DUE TO, OR AS A CONSEQUENCE OF: Diabetes Mellitus 8 years			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CVA 6 days											
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>4/4</u> 19 <u>71</u> to <u>4/21</u> 19 <u>71</u> that (2) (we) last saw the deceased alive on <u>4/21</u> 19 <u>71</u> and that (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <i>[Signature]</i> MD				23B. DATE SIGNED <u>4/21/71</u>							
23C. PHYSICIAN'S NAME (Type) JEFF BRINKER M.D.				23D. ADDRESS Johns Hopkins Hospital							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE <u>4-25-71</u>				24C. NAME OF CEMETERY OR CREMATORY MT. CALVARY CEMETERY			
24D. LOCATION Anne Arundel Co., Md.				25A. DATE REC'D BY HEALTH DEPT. APR 29 1971				25B. NAME OF REGISTRAR Robert E. Taylor, M.D.			
25C. FUNERAL DIRECTOR Randolph Collick				25D. ADDRESS 2431 E. Oliver St.							

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 4186

BIRTH NO.

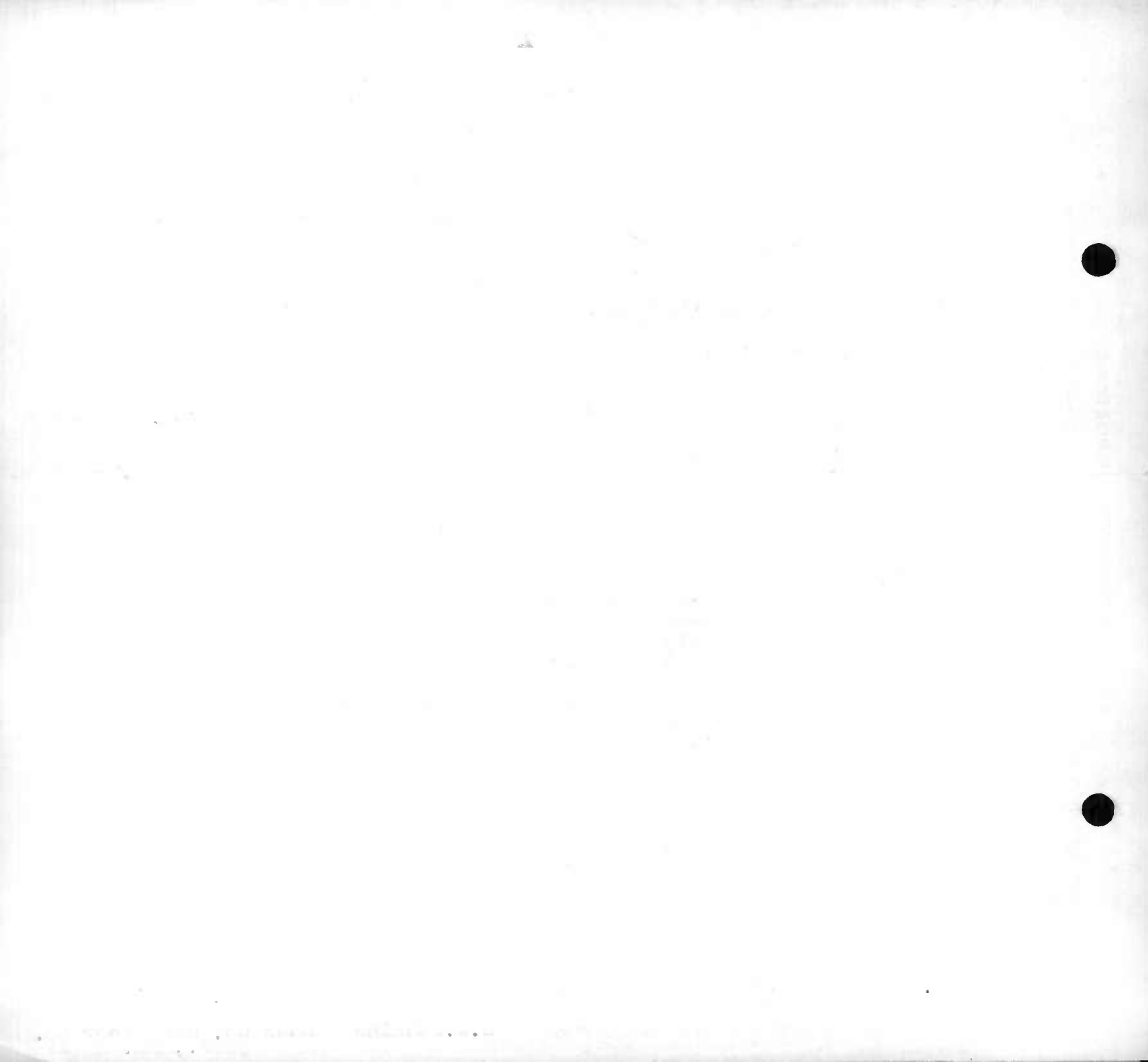
1. NAME OF DECEASED (Type or Print) BEATRICE JOHNSON (BANKS)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> April 28, 1971		Month Day Year Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 907 N. Caroline Street		3. DATE PRONOUNCED DEAD Month Day Year Hour April 28, 1971 4:55 P. M.		
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 704				
6. SEX Female	7. RACE Negro	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore
9. DATE OF BIRTH 4-9-33		10. AGE (In years lost birthday) 38		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY?		E. STREET AND NUMBER 907 N. Caroline Street
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME James Banks
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		15. MOTHER'S MAIDEN NAME Alma Douglas
18. INFORMANT Mrs. Alma Douglas		ADDRESS 1422 Edison Hwy.		
19. E887X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Post-traumatic epilepsy DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Unknown		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Unknown
22D. TIME OF INJURY (APPROX.) 6-23-60		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Fell, sustaining head injury
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED April 29, 1971				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-3-71		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery
24D. LOCATION (City, town, or county) (State) Balto., Md.				
25A. DATE REC'D BY HEALTH DEPT. APR 29 1971		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR Wm C March
				ADDRESS 928 E. North Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 4187</u>	
BIRTH NO. <u>71 4187</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>William J. Hinkle</u>			2. DATE AND HOUR OF DEATH <u>April 28, 1971 9:00 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>3 Church Home & Hospital</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2710</u>		
5. SEX <u>M</u>			6. RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>9/13/03</u>			9. AGE (In years lost birthday) <u>67</u>		10. UNDER 1 Yr. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Kansas</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13. FATHER'S NAME <u>Edward R. Hinkle</u>			14. MOTHER'S MAIDEN NAME <u>Jennie E. Ford</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>212 10 7195</u>		17. INFORMANT <u>Mrs. Hazel R. Hinkle (same)</u>
18. <u>285.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cordiac Arrest</u> CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Congestive Heart Failure</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Aneurysm, Upper GI Bleeding</u> (C) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>40 min</u>					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>II</u>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (mostly medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>4/22/71</u> 19 <u>71</u> to <u>4/28</u> 19 <u>71</u> that (1) (we) last saw the deceased alive on <u>4/28/71</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>4/28/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>F. R. OZV I</u>				23D. ADDRESS <u>Church Home & Hospital, Baltimore</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Rem. Burial</u>		24B. DATE <u>5/1/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mount Hope</u>	
24D. LOCATION (City, town, or county) <u>Mount City, Missouri</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 29 1971</u>			
25B. NAME OF REGISTRAR <u>R. E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. 21212</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 4188</u>	
BIRTH NO. <u>71 4188</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>SCHLUETER, William A.</u>			2. DATE AND HOUR OF DEATH <u>4/28/71</u> <u>2 30</u> P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 Union Memorial Hospital</u>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>904</u>		
			C. CITY OR TOWN <u>Balto</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>712 Exeter Ave</u>		
5. SEX <u>M.</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-24-02</u>	9. AGE (in years last birthday) <u>68</u>	10. Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED LABORER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>SCHENUIT RUBBER CO.</u>	11. BIRTHPLACE (State or foreign country) <u>WISCONSIN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>Schlueter, William</u>			14. MOTHER'S MAIDEN NAME <u>Viola Peters</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-12-0362</u>	17. INFORMANT <u>Mrs. Nannie Schlueter (same)</u>		
18. <u>1929</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CNS. metastasis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Indifferentiated Co. c systemic metastasis</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Depression (organic?)</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u> <u>?</u>		
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>4/28</u> to <u>4/28</u> 19 <u>71</u> and that (2) (we) last saw the deceased alive on <u>4/28</u> 19 <u>71</u> and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Charles F. Jenkins</u>			23B. DATE SIGNED <u>4/28/71</u>		23C. PHYSICIAN'S NAME (Type) <u>C. FAZEKAS MD</u>
23D. ADDRESS <u>M. M. H.</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>5/3/71</u>	24C. NAME OF CEMETERY or CREMATORY <u>Meadowridge Mem. Park</u>		24D. LOCATION (City, town, or county) (State) <u>Wash. Blvd. Dorsey, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 29 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. 21212</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 4189
BIRTH NO. M-460		1. NAME OF DECEASED (Type or Print) ELIZABETH MILLER		
2. DATE AND HOUR OF DEATH 4-28-71		M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION MT. SINAI NURSING HOME		A. STATE MARYLAND		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4613 PARK HEIGHTS AVE		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 10/15/86		9. AGE (in years last birthday) 84		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME BIELSKI
14. MOTHER'S MAIDEN NAME UNKNOWN		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 21310 1023		17. INFORMANT DANIEL SMITH 3928 CLAREMONT ST.		
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Anteaparcia		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Anteaparcia		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic carci		
(C) old fracture of femur				
MEDICAL CERTIFICATION				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from Jan 68 19 to June 71 19 that (I) (we) last saw the deceased alive on June 71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE [Signature]		23B. DATE SIGNED 4/30/71		23C. PHYSICIAN'S NAME (Type) VASH
23D. ADDRESS 206 S 612 MOR ST		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		
24B. DATE 5/1/71		24C. NAME OF CEMETERY or CREMATORY HOLY ROSARY CEMETERY		24D. LOCATION (City, town, or county) (State) DUNDALK MARYLAND
25A. DATE REC'D BY HEALTH DEPT. APR 29 1971		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR JOHN M. WEBER & SONS INC 401 S. CHESTER ST.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				CERTIFICATE OF DEATH		REG. NO. 71 4130	
BIRTH NO. 7-260		71 4130		1. NAME OF DECEASED (Type or Print) FISHER, ELIZABETH IRENE		2. DATE AND HOUR OF DEATH APRIL 28, 1971 7:53PM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		A. STATE MARYLAND B. COUNTY BALTIMORE COUNTY		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 1642 KIRKWOOD RD		5. SEX FEMALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 01 16 01		9. AGE (In years last birthday) 70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED BOOKKEEPER		10B. KIND OF BUSINESS OR INDUSTRY PLUMBING & HEATING SUPP.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME GEORGE FISHER				14. MOTHER'S MAIDEN NAME CARRIE (JACKSON)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-20-2654		17. INFORMANT ST AGNES RECORDS-BALTO MD 21229 ADDRESS			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: hypoxia			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: Myocardial failure			
				(C) hyperthyroidism			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from APRIL 19 19 71 to APRIL 28 19 71 that (I) (we) last saw the deceased alive on APRIL 28 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature]				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) G. PATRICK, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5-1-71		24C. NAME of CEMETERY or CREMATORY DROID RIDGE CEMETERY		24D. LOCATION (City, town, or county) BALTO. (State) MD.	
25A. DATE REC'D BY HEALTH DEPT. APR 29 1971		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR WIEBER FUNERAL HOME		25D. ADDRESS 53 CEDRON ST BALTO.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

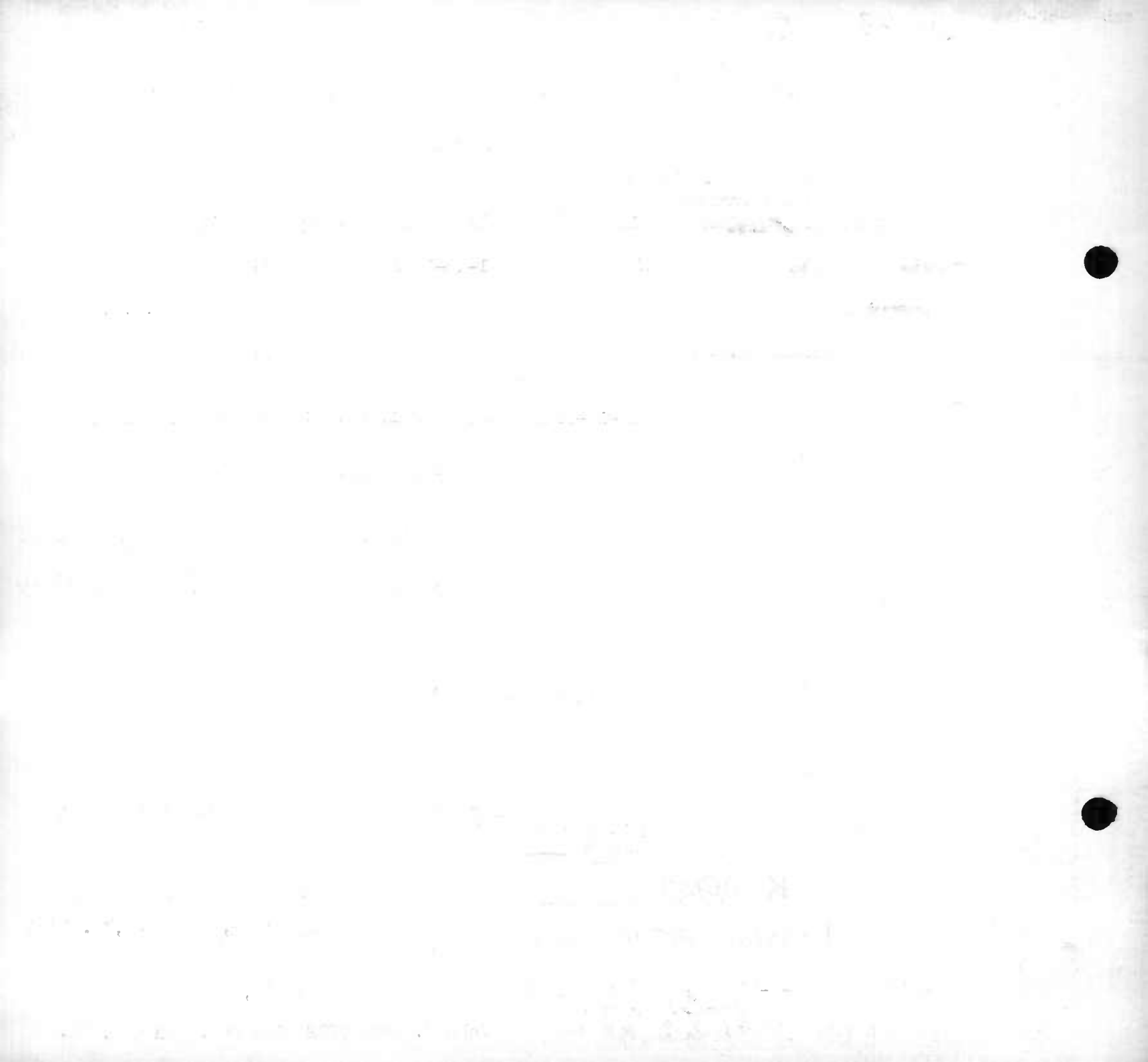
Baltimore City Health Department				REG. NO. 71 4191	
1. NAME OF DECEASED (Type or Print) <i>Patrick Young</i>		2. DATE AND HOUR OF DEATH <i>April 19, 1971 5:25 A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Prince Georges</i>			
FULL NAME OF DECEASED (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CERTIFICATE AMENDED <i>The Johns Hopkins Hospital 5-13-71</i>		C. CITY OR TOWN <i>Sutland</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>Sutland, Md.</i>					
5. SEX <i>Male</i>	6. RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 11/01/68</i>	9. AGE (in years last birthday) <i>2 1/2</i>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Cheverly, Maryland</i>	
13. FATHER'S NAME <i>Clarence Young</i>		14. MOTHER'S MAIDEN NAME <i>Lillian Agatha Turner</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH <i>75151</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Biliary atresia</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>7/1</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>April 18 1971</i> to <i>April 19 1971</i> that (I) (we) last saw the deceased alive on <i>April 19 1971</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>H. Arkans</i>		23B. DATE SIGNED <i>4-19-71</i>		23C. PHYSICIAN'S NAME (Type) <i>Howard Arkans, M.D.</i>	
23D. ADDRESS <i>The Johns Hopkins Hospital</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4-22-71</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Carroll Chapel Church</i>	
24D. LOCATION (City, town, or county) (State) <i>Mitchellville, Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>APR 20 1971</i>		25B. NAME OF FUNERAL DIRECTOR <i>Martell Adams</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Aguasco, Md.</i>	

Child's Birth Certificate from State of
Maryland 5-13-71 M.H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

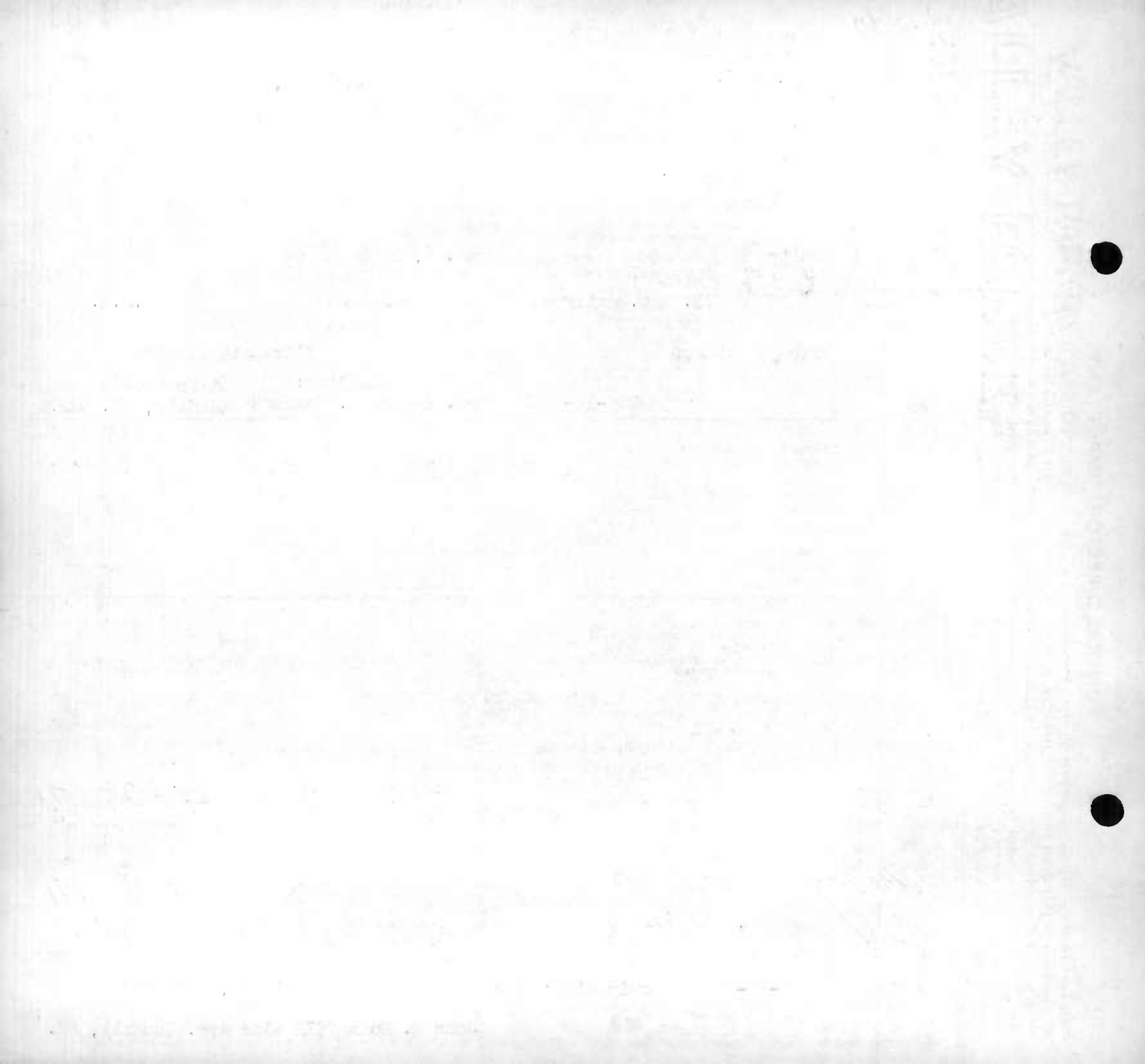
BIRTH NO. <u>D-263</u>		BALTIMORE CITY HEALTH DEPARTMENT		71 4192	
1. NAME OF DECEASED (Type or Print) <u>Marie Dujardin</u>		2. DATE AND HOUR OF DEATH <u>4-28-71 10:15 AM</u>		REG. NO. <u>71 4192</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>31 Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Female</u>		6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>1-20-1885</u>		9. AGE (In years last birthday) <u>86</u>		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Belgium</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Joseph Boucha</u>		14. MOTHER'S MAIDEN NAME <u>??</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>014-16-5540</u>		17. INFORMANT <u>Records: BCH 4940 Eastern Avenue 21224</u>	
18. <u>412.4</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <u>4-22-71</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>embolectomy from hip</u> 20A. AUTOPSY? (Yes or No) <u>NO</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from <u>4-7-71</u> 19 <u>71</u> to <u>4-28-71</u> 19 <u>71</u> and that (I) (we) lost saw the deceased alive on <u>10:00 AM 4-28-71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE <u>K. AFSARI</u> 23B. DATE SIGNED <u>4-28-71</u> 23C. PHYSICIAN'S NAME (Type) <u>Khosrow AFSARI M.D.</u> 23D. ADDRESS <u>4940 Eastern Avenue, Baltimore, Md. 21224</u> 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> 24B. DATE <u>5-1-71</u> 24C. NAME OF CEMETERY or CREMATORY <u>Bel Air Memorial Gardens</u> 24D. LOCATION (City, town, or county) (State) <u>Bel Air, Maryland</u> 25A. DATE REC'D BY HEALTH DEPT. <u>APR 29 1971</u> 25B. NAME OF REGISTRAR <u>John J. Duda</u> 25C. FUNERAL DIRECTOR <u>John J. Duda</u> 25D. ADDRESS <u>7922 Wise Ave. Dundalk, Md.</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4193	
L-340 71 4193				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Selma E. Little		April 28, 1971 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 90 Edgewood Nursing Home 6000 Bellona Avenue			A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Dundalk D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 2903 Dunmore Road		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 6, 1896	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY B. & O. Railroad		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Sigbord Johnson		
14. MOTHER'S MAIDEN NAME Elizabeth Elfeson			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 705-10-3261			17. INFORMANT Daughter: Mrs. Howard R. Doxzon ADDRESS 65 Broadship Road Dundalk, Md. 21222		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH CARCINOMA of Liver - (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-7 1971 to 4-28 1971, that (I) (we) lost saw the deceased alive on 4-27 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Anthony F. Carozza				23B. DATE SIGNED 4-28-1971	
23C. PHYSICIAN'S NAME (Type) Anthony F. Carozza				23D. ADDRESS 5217 York Rd. Baltimore Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-30-71		24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery	
24D. LOCATION Baltimore, Maryland		24E. DATE REC'D BY HEALTH DEPT. APR 29 1971		24F. NAME OF REGISTRAR John J. Duda	
24G. FUNERAL DIRECTOR John J. Duda		24H. ADDRESS 7922 Wise Ave. Dundalk, Md.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

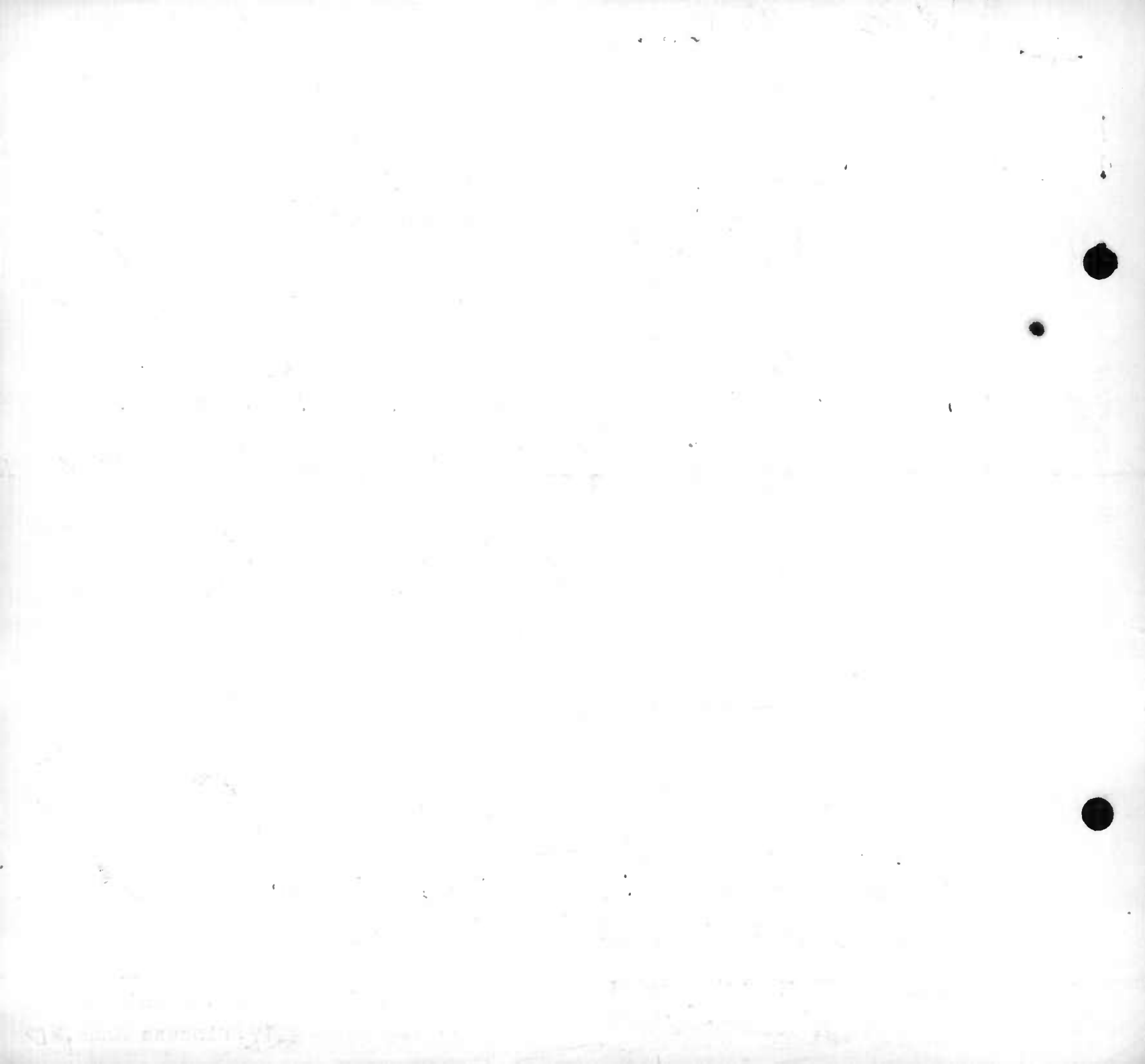
BIRTH NO. <u>L-200</u>				BALTIMORE CITY HEALTH DEPARTMENT				71 4194				71 4194			
1. NAME OF DECEASED (Type or Print) <u>Marian M. Lewis</u>				2. DATE AND HOUR OF DEATH <u>4-26-71</u> <u>800 P.M.</u> M.											
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)											
FULL NAME OF HOSPITAL OR INSTITUTION <u>Balt. City Hosp</u>				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>4940 Eastern Avenue</u>				A. STATE <u>Maryland</u>				B. COUNTY <u>Baltimore</u>			
C. CITY OR TOWN <u>Edgemere</u>				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				E. STREET AND NUMBER <u>2513 Wagner Ave</u>				21219 005			
5. SEX <u>Female</u>		6. RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/19/26</u>		9. AGE in years (last birthday) <u>45</u>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Sydney Williams</u>				14. MOTHER'S MAIDEN NAME <u>Ethel Phillpots</u>											
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>215-22-1623</u>				17. INFORMANT <u>BCH-Records Baltimore, Md. 21224</u>				ADDRESS <u>4940 Eastern Avenue</u>			
18. <u>430X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Pulmonary Embolism</u>				CAUSE OF DEATH								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:											
				(B) DUE TO, OR AS A CONSEQUENCE OF:											
				(C) DUE TO, OR AS A CONSEQUENCE OF:											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).															
19A. DATE OF OPERATION <u>4/20/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)											
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?											
22. I certify that (1) (this hospital) attended the deceased from <u>4/20/71</u> 19 <u>71</u> to <u>4/26</u> 19 <u>71</u> that (1) (we) last saw the deceased alive on <u>4/26</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.															
23A. SIGNATURE <u>Allan Krumholtz</u>				23B. DATE SIGNED <u>4/27/71</u>											
23C. PHYSICIAN'S NAME (Type) <u>Allan Krumholtz</u>				23D. ADDRESS <u>BCH- 4940 Eastern Ave.</u>											
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal Burial</u>		24B. DATE <u>4-30-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Cedardale Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Mullins, Marion Co. South Carolina</u>									
25A. DATE REC'D BY HEALTH DEPT. <u>APR 29 1971</u>				25B. NAME OF REGISTRAR <u>John J. Duda</u>				25C. FUNERAL DIRECTOR <u>John J. Duda</u>				ADDRESS <u>7922 Wise Ave. Dundalk, Md.</u>			

2013 WINTER
2/18/13

FUNERAL DIRECTOR: IMPORTANT

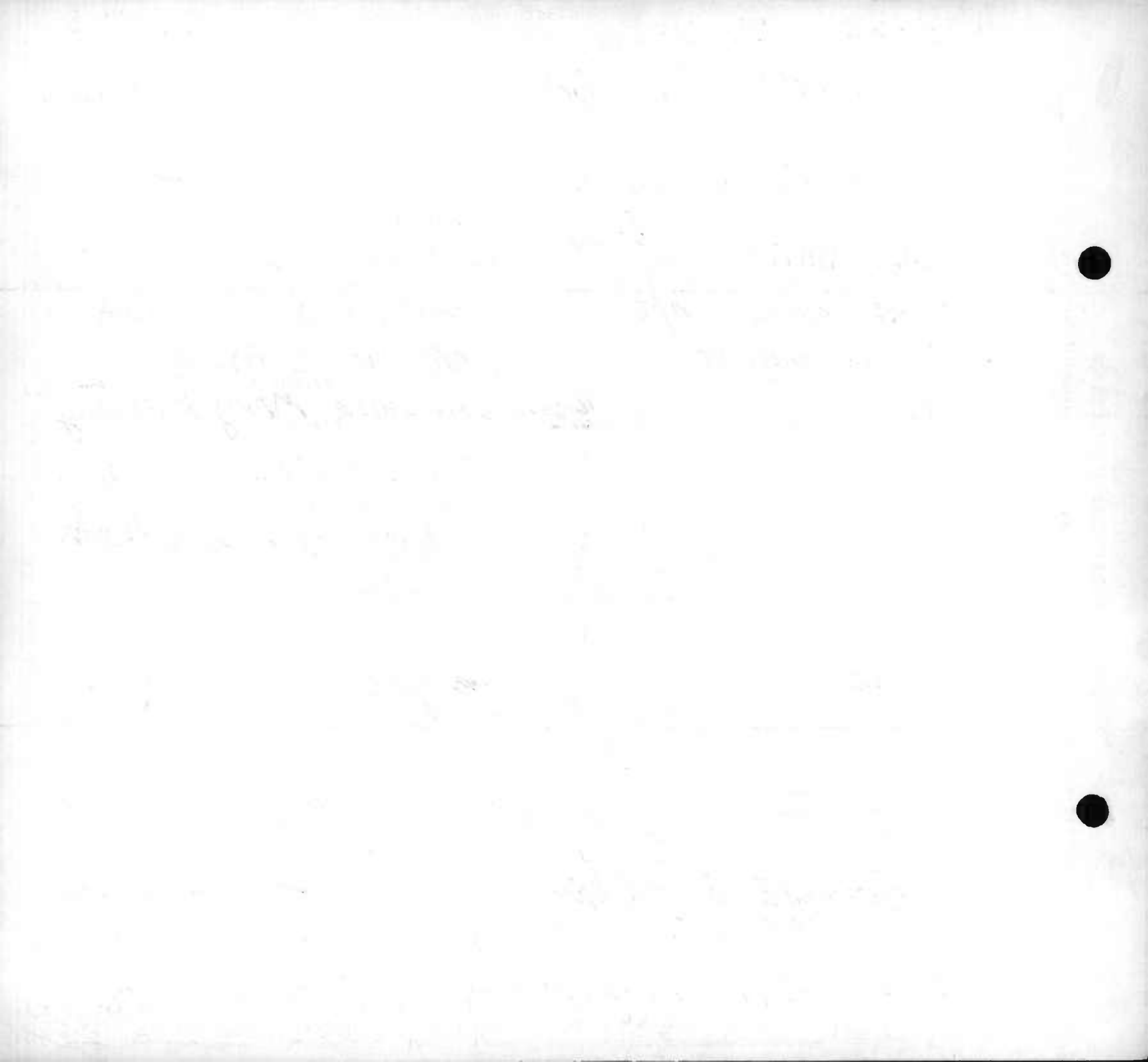
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X REG. NO. 71 4195	
<div style="display: flex; justify-content: space-between;"> P. 456 71 4195 </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MINNIE PALMER		28 April 1971 1 30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY Hospital 38			A. STATE Md. Somerset 6900		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN PRINCESS ANNE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Female			6. RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 8-31-31	
None				9. AGE (In years last birthday) 39	
13. FATHER'S NAME JAMES MULLINS			14. MOTHER'S MAIDEN NAME Emma Maggie		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT George F. Palmer, Princess Anne, Md
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH PERITONITIS secondary to (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Common bile duct injury (B) Peptic ulcer disease possible DUE TO, OR AS A CONSEQUENCE OF: 3rd degree burn syndrome (C) Renal Tubular necrosis, acute		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4-14-71 2-3 yrs 5 days
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetes mellitus					
19A. DATE OF OPERATION 4-14-71 4-16		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Peptic ulcer d-		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hospital		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Univ. Hosp 4-01	
21D. TIME OF INJURY (APPROX.) 4-14-71		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Injury to Common Bile duct during Surgery	
22. I certify that (I) (this hospital) attended the deceased from 3-24-71 to 4-28-71 that (I) (we) last saw the deceased alive on 4-28-71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael P. Buchness			23B. DATE SIGNED 4-28-71		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) MICHAEL P. BUCHNESS			23D. ADDRESS University Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/1/71		24C. NAME OF CEMETERY or CREMATORY Carmal	
24D. LOCATION Princess Anne, Maryland		24E. LOCATION (City, town, or county) (State) Princess Anne, Md			
25A. DATE REC'D BY HEALTH DEPT. APR 29 1971		25B. NAME OF REGISTRAR Robert E. Taylor, JR.		25C. FUNERAL DIRECTOR William H. James, JR.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-162 71 4196		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 4196	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) RICHARD W. GOBRECHT		2. DATE AND HOUR OF DEATH 4-27-71 5:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY BALTO.		C. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION 49 NORTH CHARLES GEN. HOSP.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 12-31-05		9. AGE (In years last birthday) 65		10. Under 1 Yr. Months Days If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE		10B. KIND OF BUSINESS OR INDUSTRY apt.		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Richard Gobrecht		14. MOTHER'S MAIDEN NAME MOLLIE STAYLOR	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-16-6576		17. INFORMANT 1111 W. Lombard St. ADDRESS 21223 DAUGHTER, MARY KIESSLING	
18. 136.01		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARCINOMATOSIS, PRIMARY SITE NOT		3 mo.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: KNOWN - pass. gall bladder			
(C) _____					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 4-23-71 to 4-27-71 that (1) (we) last saw the deceased alive on 4-27-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ronald E. Gillilan MD		23B. DATE SIGNED 4-27-71		23C. PHYSICIAN'S NAME (Type) RONALD E. GILLILAN, M.D.	
23D. ADDRESS NORTH CHARLES GEN. HOSP., BALTO., MD.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 5/1/71		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cem.		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 29 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR John F. Cowan & Son Inc. 901 N. Hollins St. Balto. 23, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 4197</u>	
K-450 71 4197				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Dorothy Klein		April 29, 1971 1:55 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 91 Levindale			A. STATE B. COUNTY Md (Baltimore) 5300		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			C. CITY OR TOWN Evanston		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER 920 Ashbridge Drive		
5. SEX Female	6. RACE Human	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-14-1905	9. AGE (In years last birthday) 65	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
			11. BIRTHPLACE (State or foreign country) Canada		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Harry			14. MOTHER'S MAIDEN NAME Sarah		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	17. INFORMANT Hoop Clark		
		ADDRESS			
18. 1929 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Astro Cytoma Grade III (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 7		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from April 7, 1971 to April 29, 1971 that (X) (we) last saw the deceased alive on April 29, 1971 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.					
23A. SIGNATURE Theodore R. Reiff, M.D.			23B. DATE SIGNED April 29, 1971		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS Levindale		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4/30/71		24C. NAME OF CEMETERY OR CREMATORY Chynok Amens	
				24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. APR 29 1971		25B. NAME OF REGISTRAR E. E. E.		25C. FUNERAL DIRECTOR Sylvan Lewis 25m 9610	
				ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-230 71 4198		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 4198	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Beckwith, Richard		2. DATE AND HOUR OF DEATH April 29, 1971 3:30pm M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY 2734		5. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Produce SALESMAN		10B. KIND OF BUSINESS OR INDUSTRY Produce		8. DATE OF BIRTH April 18, 1906	
13. FATHER'S NAME RICHARD THOMAS Beckwith		14. MOTHER'S MAIDEN NAME ANNA UNKNOWN		9. AGE On years (last birthday) 65 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-10-7161A		11. BIRTHPLACE (State or foreign country) MARYLAND	
17. INFORMANT SARAFINA Beckwith (wife)		ADDRESS		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH CAUSE OF DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of Lung		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Chronic Obstructive Pulmonary Disease					
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) None		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) None	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) None		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? None	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4/22/71 19 to 4/29 19 71 that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on 4/29 19 71 and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (he) (did) (did not) view the body after death.					
23A. SIGNATURE 		23B. DATE SIGNED April 29, 1971		23C. PHYSICIAN'S NAME (Type) Luis Quintado MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/29/71		24C. NAME OF CEMETERY or CREMATORY HOLY THOMAS CEMETERY	
24D. LOCATION (City, town, or county) (State) BLK RIDGE MARYLAND		25A. DATE REC'D BY HEALTH DEPT. APR 29 1971		25B. NAME OF REGISTRAR Robert E. [unclear]	
25C. FUNERAL DIRECTOR Dipper Bros Inc		ADDRESS 7110 BELAIR ROAD			

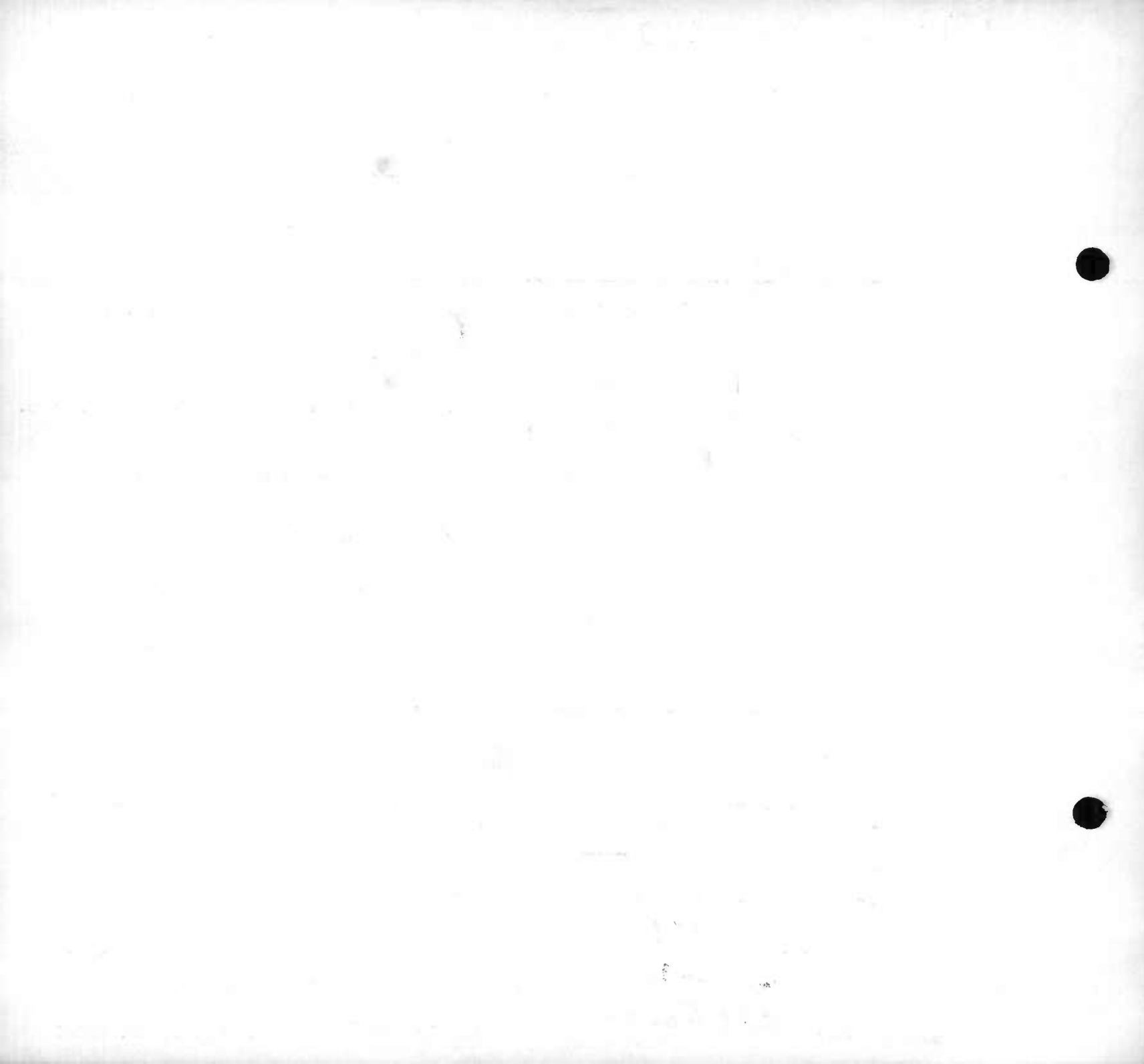
SECTION 11.001.001

AM 1-1-1911

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

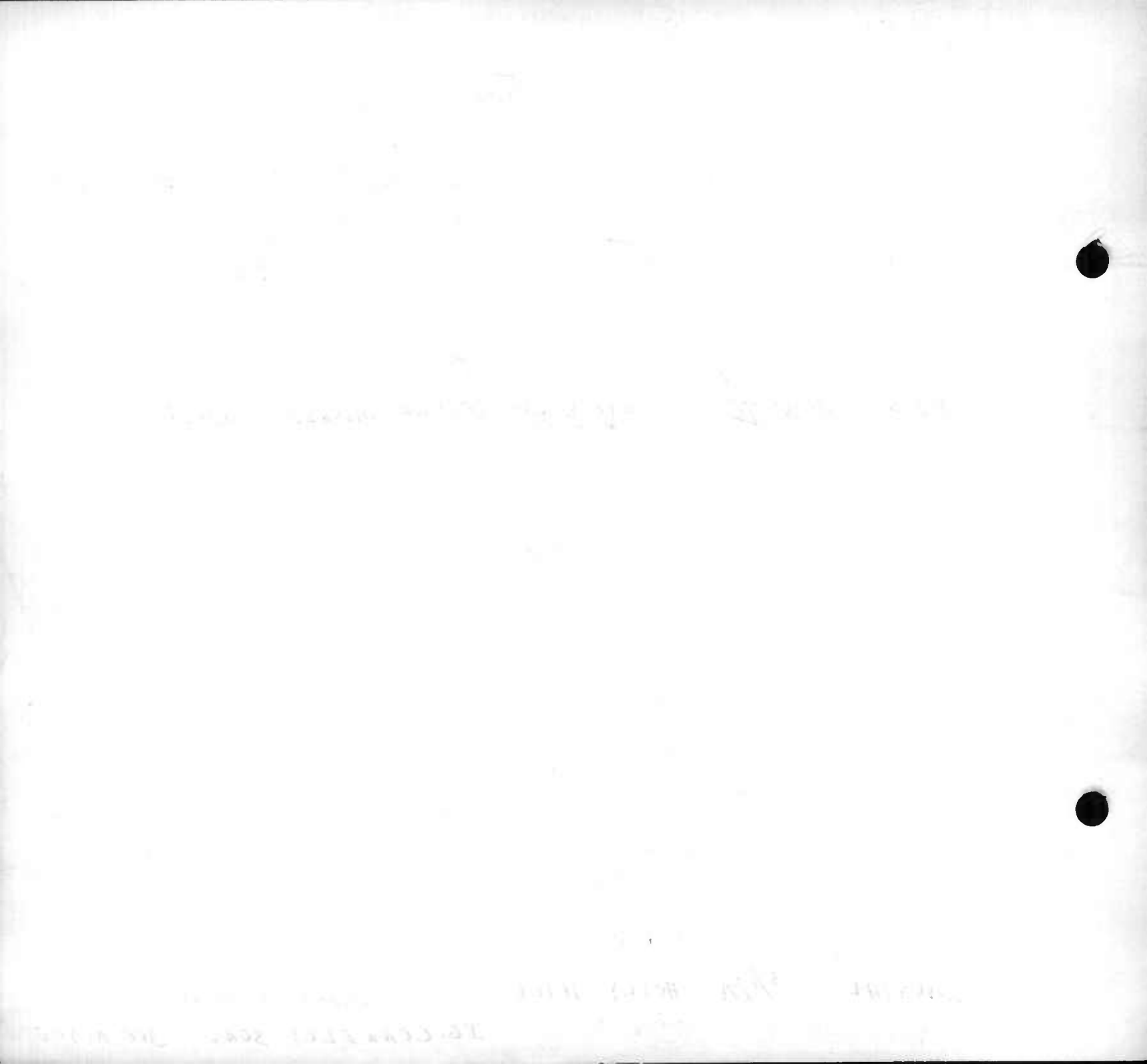
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 4198</u>
BIRTH NO. <u>D-200</u>		71 4198		
1. NAME OF DECEASED (Type or Print) CHARLES FREDERICK DASCH, Sr.		2. DATE AND HOUR OF DEATH 27 April 1971 <u>9¹⁵P</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 90 House in the Pines Nursing Home 21206		A. STATE Md. B. COUNTY 2642		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 4353 Robertson Ave. 21206		
5. SEX Male	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 24 Jan 25	9. AGE (In years last birthday) 46
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) mechanic		10B. KIND OF BUSINESS OR INDUSTRY Dairy Products		11. BIRTHPLACE (State or foreign country) Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Charles Howard Dasch		14. MOTHER'S MAIDEN NAME Mary E. Dinged		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW II and Korea		16. SOCIAL SECURITY NO.		
		17. INFORMANT Mrs. Elizabeth M. Dasch, 4353 Robertson Ave.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Chronic Nephritis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic Nephritis		
		(B) DUE TO, OR AS A CONSEQUENCE OF: Diabetes mellitus		
		(C) Chronic Nephritis, Blind, Angina Heart Disease		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION 4/30/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (the hospital) attended the deceased from 4/31/71 to 4/27/71 and that (I) (we) last saw the deceased alive on 4/27/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Albert B. Bradley		23B. DATE SIGNED 4/30/71		
23C. PHYSICIAN'S NAME (Type) A.B. Bradley, MD		23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 30 Apr 71		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore Co., Md.				
25A. DATE REC'D BY HEALTH DEPT. MAY 3 1971		25B. NAME OF REGISTRAR Robert E. Galtman, R.R.		25C. FUNERAL DIRECTOR Ullrich Funeral Homes, Balto., Md. 21206
25D. ADDRESS				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-500 71 4200		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		71 4200	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>John Patrick Mooney, Jr.</u>		2. DATE AND HOUR OF DEATH <u>4/27/71</u> <u>8:30 P M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>38 University Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u>		5. CITY OR TOWN <u>ESSEX</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <u>M</u> 7. RACE <u>W</u> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH <u>7-14-27</u> 10. AGE (In years last birthday) <u>43</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u> 12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Worker</u>		10B. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME <u>John P. Mooney</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>216-203884</u>		14. MOTHER'S MAIDEN NAME <u>H Ellen Morrow</u>	
17. INFORMANT <u>JOYCE MOONEY ABOVE</u>		ADDRESS			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>BRONCHOGENIC CARCINOMA</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>with local and regional metastasis</u> <u>Hypercalcemia 20 to (A)</u> <u>Hypotension 20 to (B)</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>4-27-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4-27</u> 19 <u>71</u> to <u>4-27</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>4-27</u> 19 <u>71</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>H. Briele, Jr. MD.</u>		23B. DATE SIGNED <u>4/27/71</u>		23C. PHYSICIAN'S NAME (Type) <u>H. Briele, Jr. MD.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>5/1/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>HOLLY HILL</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 3 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Seabey, Jr.</u>		25C. FUNERAL DIRECTOR <u>J.G. CONNALLY SONS</u>	
25D. ADDRESS <u>300 MACE</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 71 4201	
M-460 71 4201 BIRTH NO. 1. NAME OF DECEASED (Type or Print) MARX D. MOLLER		2. DATE AND HOUR OF DEATH 4/28/71 8:05 A.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 34 Bow Secours Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTO. C. CITY OR TOWN ESSEX BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 52 DOGWOOD DRIVE			
5. SEX MALE		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/21/12	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ADOLPH MOLLER				14. MOTHER'S MAIDEN NAME BERTHA DIETRICH			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK		16. SOCIAL SECURITY NO. 201-16-3174		17. INFORMANT ADDRESS RUTH MOLLER ABOVE			
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 15%; text-align: center;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH </div> </div> <div style="margin-top: 10px;"> (A) IMMEDIATE CAUSE Widespread metastasis DUE TO, OR AS A CONSEQUENCE OF: bone & pulmonary (B) Carcinoma Prostate DUE TO, OR AS A CONSEQUENCE OF: (C) </div>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 4/27/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If not, medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) A		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/21/71 19 71 to 4/28/71 19 71 that (I) (we) last saw the deceased alive on 4/27/71 19 71 and that (in) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE K. Zekry				23B. DATE SIGNED 4/28/1971		23C. PHYSICIAN'S NAME (Type) KAMAL ZEKRY M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL		24B. DATE 5/1/79		24C. NAME OF CEMETERY OR CREMATORY YELLOW CREEK		24D. LOCATION (City, town, or county) (State) YELLOW CREEK PA.	
25A. DATE REC'D BY HEALTH DEPT. MAY 3 1971		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR ADDRESS Connelly Funeral Home 300 Main Ave			

1940

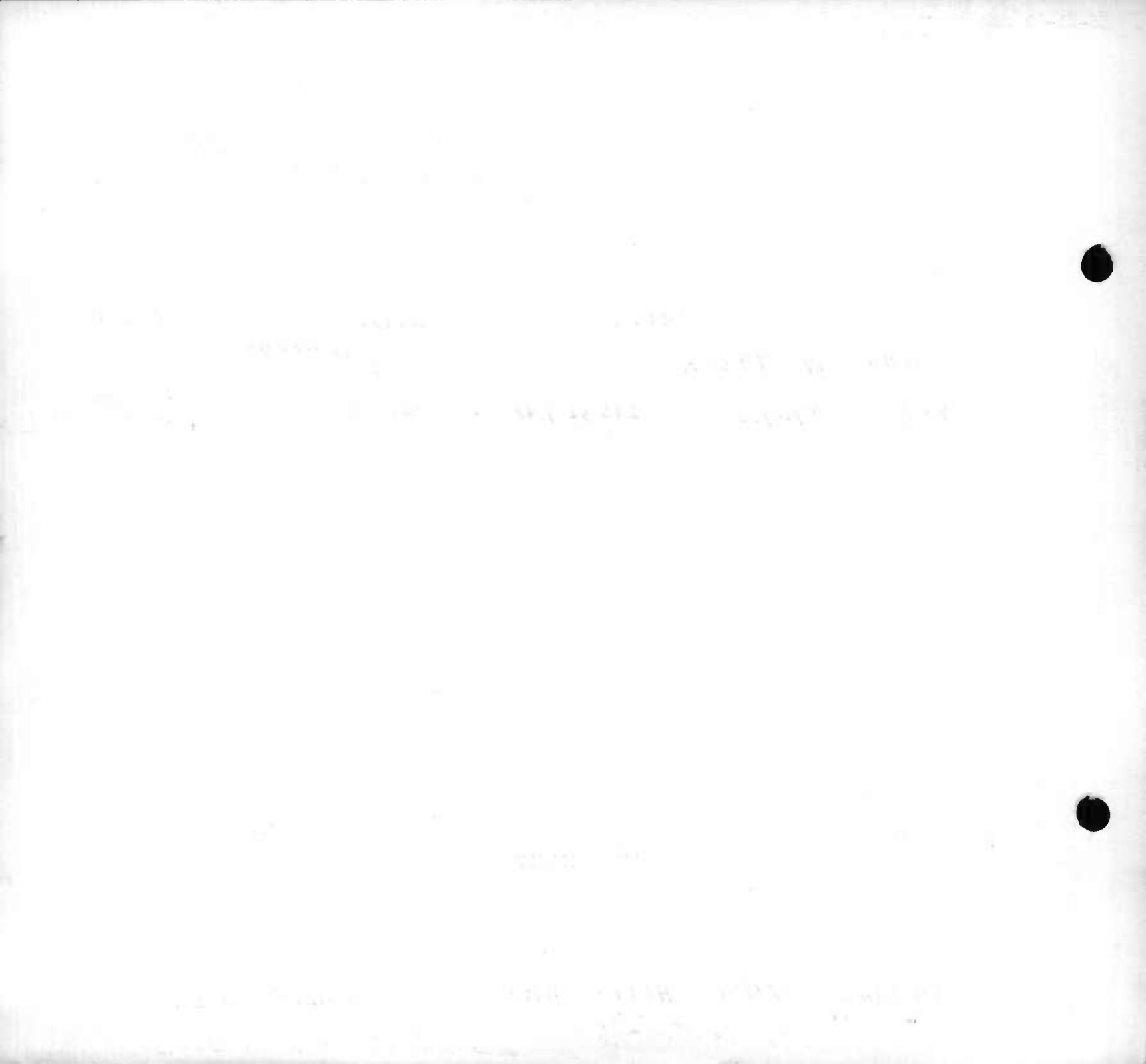
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 71 4202	
T-260		71 4202		BIRTH NO.			
1. NAME OF DECEASED (Type or Print) Mr. TYSOR, JACK LEE				2. DATE AND HOUR OF DEATH April 28 th , 1971 1st 4:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITAL, BALTIMORE, MARYLAND 21224		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE MARYLAND 21220 BALTO 5300		B. COUNTY	
				C. CITY OR TOWN BALTIMORE ESSEX		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2217, CORAL THORNE RD.		21220	
5. SEX MALE	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-19-1935	9. AGE (in years last birthday) 36 yrs.	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY PAINT		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN A. TYSOR				14. MOTHER'S MAIDEN NAME WHITBY Elsie deceased			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 11/24/52		16. SOCIAL SECURITY NO. 213-32-9768		17. INFORMANT BCH RECORDS:		ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224	
18. 796.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE Aspiration Pneumonia DUE TO, OR AS A CONSEQUENCE OF: (B) Degeneration of brain secondary DUE TO, OR AS A CONSEQUENCE OF: (C) to trauma.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that XXX (this hospital) attended the deceased from April 1st 1971 to April 28th 1971 that (X we) last saw the deceased alive on April 28th 1971 and that in (my) (see) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Prakash G. Sane M.D.				23B. DATE SIGNED April 28 th , 1971			
23C. PHYSICIAN'S NAME (Type) PRAKASH G. SANE, M.D.		23D. ADDRESS BALTIMORE CITY HOSPITAL, BALTIMORE 21224					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5/1/71		24C. NAME of CEMETERY or CREMATORY HOLLY HILL		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. MAY 2 1971		25B. NAME OF REGISTRAR R. E. Connelley		25C. FUNERAL DIRECTOR R. E. Connelley		ADDRESS 3000 Madison Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-200 71 4203		BALTIMORE CITY HEALTH DEPARTMENT DR. ATTAR 40-20-03 71 42036 REG. NO. 71 42036 RN TS SP	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Cox, Warren Harding</i>	
2. DATE AND HOUR OF DEATH <i>4-29-71 4:30 A.M.</i>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
FULL NAME OF HOSPITAL OR INSTITUTION <i>38 Univ. of Md. Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)	
5. SEX <i>M</i>		6. RACE <i>W</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>5-28-22</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Electrician</i>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Va</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>Gilbert Cox</i>		14. MOTHER'S MAIDEN NAME <i>Florence Hubbel</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes 1944-46</i>		16. SOCIAL SECURITY NO. <i>229-16-2364</i>	
17. INFORMANT <i>Wife, Kathleen Cox</i>		ADDRESS <i>ABOVE</i>	
18. <i>162-1</i>		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Obstruction of Airway with Carcinoma</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Carcinoma of Lung</i> DUE TO, OR AS A CONSEQUENCE OF:	
		(C) <i>Superior Vena Caval Syndrome</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3-30</i> 19 <i>71</i> to <i>4-29</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>4-29</i> 19 <i>71</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>H. Jae Ihm MD</i>		23B. DATE SIGNED <i>4/29/71</i>	
23C. PHYSICIAN'S NAME (Type) <i>H. JAE IHM MD</i>		23D. ADDRESS <i>Univ. of Md. Hosp.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>5/3/71</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>OAK LAWN</i>		24D. LOCATION (City, town, or county) (State) <i>BALTO. MD.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 3 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Kelly, Jr.</i>	
25C. FUNERAL DIRECTOR <i>J.G. CONNELLY SONS</i>		ADDRESS <i>300 MACE</i>	

1915-16-17

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department									
71 4204					71 4204				
BIRTH NO. <u>G-622</u>					REG. NO. <u>71 4204</u>				
1. NAME OF DECEASED (Type or Print) GORSUCH, EDWARD CONSOR					2. DATE AND HOUR OF DEATH APRIL 29, 1971 10:55 A.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE COUNTY C. CITY OR TOWN RELAY D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 5110 WALNUT ST				
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 07-12-04	9. AGE (in years lost birthday) 66	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MAINTENANCE CAREY MACHINERY					10B. KIND OF BUSINESS OR INDUSTRY MARYLAND				
11. BIRTHPLACE (State or foreign country) MARYLAND					12. CITIZEN OF WHAT COUNTRY? U S A				
13. FATHER'S NAME ZACHARIAS GORSUCH					14. MOTHER'S MAIDEN NAME HENRIETTA EGERS				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO					16. SOCIAL SECURITY NO. 213-10-8075				
17. INFORMANT Mrs. Ruth M. Gorsuch, 5110 Walnut St. 21227					ADDRESS ST AGNES HOSP RECORDS BALTO MD 21229				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr?				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulm edema (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Hypertension - lung metastases									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -					
22. I certify that (I) (this hospital) attended the deceased from APRIL 17 1971 to APRIL 29 1971 that (I) (we) last saw the deceased alive on APRIL 29 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Rauony					23B. DATE SIGNED 04 29 71				
23C. PHYSICIAN'S NAME (Type) B. LERBOON M.D.					23D. ADDRESS ST AGNES HOSP. CATON & WILKENS AVE				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-3-1971		24C. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		24D. LOCATION (City, town, or county) (State) Washington Blvd. Howard Co., Md.			
25A. DATE REC'D BY HEALTH DEPT. MAY 3 1971		25B. NAME OF REGISTRAR E. G. G. G.		25C. FUNERAL DIRECTOR ADDRESS Howatd H. Hubbard, 4107 Wilkens Ave. 21229					

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4205	
S-436 71 4205		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Slattery, William J. Sr.		April, 29th, 1971		12:05AM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
40 Saint Agnes Hospital Caton & Wilkens Ave. 21229		Maryland		Baltimore	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		1422 Sulphur Spring Rd. 21227			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: Hours: Min.
m	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10/20/03	67	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Salesman		Leonard Paper Co.		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Charles Slattery, Sr.		Alice Hildebrand		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		215-03-8562		21227	
		Mrs. Millie V. Slattery, 1422 Sulphur Spring Rd			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Acute Myocardial Infarction	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		Coronary Artery Disease	
		(C)		Pulmonary Edema	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		5-3-1971		New Cathedral Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAY 3 1971		Robert E. Seabury, M.D.		Howard H. Hubbard, 4107 Wilkens Ave. 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>5-530</u>		BALTIMORE CITY HEALTH DEPARTMENT		71 4206		CERTIFICATE OF DEATH		71 4206	
1. NAME OF DECEASED (Type or Print) <u>Barbara S. Smith</u>				2. DATE AND HOUR OF DEATH <u>4/27/71</u> <u>10:30 P.M.</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Maryland General Hosp.</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTO.</u> C. CITY OR TOWN <u>BALTO.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Maryland General Hosp.</u>				E. STREET AND NUMBER <u>Rt 2, Box 107-Severn, MD, 21144</u>					
5. SEX <u>F</u>	6. RACE <u>N W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/24/29</u>	9. AGE (In years last birthday) <u>42</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk - None</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Otto Weis</u>				14. MOTHER'S MAIDEN NAME <u>Muriel Timmerman</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>090-22-7183</u>		17. INFORMANT <u>Mr. Julian Smith</u>		ADDRESS <u>Same as #4</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Gasdrointestinal hemorrhage</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Gasdro ulcer</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinoma of colon & metastases</u> (C) <u>Pulmonary emboli</u>					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Pulmonary emboli</u>					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>4/21</u> 19 <u>71</u> to <u>4/21</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>4/21</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>4/27/71</u>				23C. PHYSICIAN'S NAME (Type) <u>[Signature]</u>	
23D. ADDRESS <u>[Address]</u>				23E. DEGREE <u>[Degree]</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/13/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Cedar Grove Park</u>		24D. LOCATION (City, town, or county) (State) <u>Cedar Bluffs Md.</u>		24E. DATE REC'D BY HEALTH DEPT. <u>MAY 8 1971</u>	
25A. NAME OF REGISTRAR <u>[Name]</u>		25B. FUNERAL DIRECTOR <u>Singleton Funeral Home</u>		25C. ADDRESS <u>[Address]</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
71 4207					71 4207				
BIRTH NO. 1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
HARMAN, EDNA DOROTHY					APRIL 28, 1971 2:50A.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					A. STATE B. COUNTY				
40 ST. AGNES HOSPITAL					MARYLAND BALTIMORE 21228				
					C. CITY OR TOWN		D. INSIDE CITY LIMITS?		
					BALTIMORE CATONSVILLE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
					E. STREET AND NUMBER				
					338 KENWOOD AVE. 5300				
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
FEMALE		WHITE		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		05 18 89		81	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY				
Homemaker									
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
HENRY REIBERT					MARTHA (DITTMAR)				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.				
No					214-40-0665				
17. INFORMANT					17. ADDRESS				
					WILKENS AVES. BALTO, MD. 21229				
					ST. AGNES HOSPITAL RECORDS-CATON &				
18. CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH									
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)									
ANTECEDENT CAUSES									
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
(A) IMMEDIATE CAUSE <i>sepsis</i>									
DUE TO, OR AS A CONSEQUENCE OF:									
(B) <i>staphylococcal infection</i>									
DUE TO, OR AS A CONSEQUENCE OF:									
(C) _____									
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
<i>ASCVD, psoriasis</i>									
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
0					NO				
20A. AUTOPSY (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
NO					NO				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					21D. TIME OF INJURY (Month) (Day) (Year) (Hour)				
21E. INJURY OCCURRED					21F. HOW DID INJURY OCCUR?				
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>									
22. I certify that (X) (this hospital) attended the deceased from APRIL 4 19 71 to APRIL 28 19 71									
that (X) (we) last saw the deceased alive on APRIL 28 19 71 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXX) view the body after death.									
23A. SIGNATURE					23B. DATE SIGNED				
Horacio Guzman, M.D.					04-28-71				
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
HORACIO GUZMAN					ST. AGNES HOSPITAL				
					CATON & WILKENS AVES. BALTO., MD. 21229				
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE		24C. NAME of CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)	
Burial			4-30-1971		Loudon Park Cemetery			Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR ADDRESS			
MAY 3 1971			Robert E. Hubbard			Howard H. Hubbard, 4107 Wilkens Ave. 21229			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 71 4208</p>	
<p>BIRTH NO. Z-400 71 4208</p>		<p>1. NAME OF DECEASED (Type or Print) ELISA GRACE ZULLO</p>	
<p>2. DATE AND HOUR OF DEATH APRIL 28 1971 6:00 PM</p>		<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD NORTH CHARLES GENERAL HOSPITAL</p>	
<p>4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) MARYLAND 2748</p>		<p>5. CITY OR TOWN BALTIMORE</p>	
<p>6. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/></p>		<p>7. STREET AND NUMBER 1215 COCHRAN AVE</p>	
<p>8. SEX F</p>	<p>9. RACE W</p>	<p>10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>11. DATE OF BIRTH APRIL 2 1907</p>
<p>12. AGE (In years last birthday) 64</p>		<p>13. BIRTHPLACE (State or foreign country) ITALY</p>	<p>14. CITIZEN OF WHAT COUNTRY?</p>
<p>15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE</p>		<p>16. KIND OF BUSINESS OR INDUSTRY -</p>	
<p>17. FATHER'S NAME ANTHONY COLONELLO</p>		<p>18. MOTHER'S MAIDEN NAME ANNETTE PERSICRELLA</p>	
<p>19. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO</p>		<p>20. SOCIAL SECURITY NO. NONE</p>	<p>21. INFORMANT Michael Zullo (husband)</p>
<p>22. ADDRESS Balto Md. 21212</p>		<p>23. ADDRESS 1215 Cochran Ave.</p>	
<p>24. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Ca. stomach + liver</p>		<p>25. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II</p>	
<p>26. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>		<p>27. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>28. DATE OF OPERATION 4/24</p>	<p>29. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	<p>30. AUTOPSY? (Yes or No) NO</p>	<p>31. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>
<p>32. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>	<p>33. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	<p>34. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>35. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>	<p>36. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	<p>37. HOW DID INJURY OCCUR?</p>	
<p>38. I certify that (I) (this hospital) attended the deceased from 4/24 1971 to 4/28 1971 that (I) (we) last saw the deceased alive on 4/28/71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>39. SIGNATURE <i>[Signature]</i></p>		<p>40. DATE SIGNED 4/28/71</p>	<p>41. ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/></p>
<p>42. PHYSICIAN'S NAME (Type) TEODORO R. LARANGAL</p>		<p>43. ADDRESS NORTH CHARLES GENERAL HOSPITAL</p>	
<p>44. BURIAL CREMATION, REMOVAL (Specify) burial</p>	<p>45. DATE 5/1/71</p>	<p>46. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery</p>	<p>47. LOCATION (City, town, or county) (State) Balto. Md.</p>
<p>48. DATE REC'D BY HEALTH DEPT. MAY 3 1971</p>	<p>49. NAME OF REGISTRAR <i>[Signature]</i></p>	<p>50. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto Md. 21211</p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>M-212</u> <u>71</u> <u>4209</u>				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>71</u> <u>4209</u>	
1. NAME OF DECEASED (Type or Print) <u>Maskovyak, Michael</u>				2. DATE AND HOUR OF DEATH <u>4-29-71</u> <u>4:25</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>31</u> <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2605</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? <u>YES</u> <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>6901 Eastbrook Avenue</u> <u>21224</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-12-15</u>	9. AGE (In years, months, days) <u>56</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		
11. BIRTHPLACE (State or foreign country) <u>Ohio</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>Michael Maskovyak</u>				14. MOTHER'S MAIDEN NAME <u>Theresa Merva</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes</u> <u>WW II</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>BCH RECORDS:</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>	
18. <u>43601</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>! Probable Pulm. Embolism</u> <u>CVA; Angina Pectoris</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Hypertension</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW OLD INJURY OCCURRED?			
22. I certify that <u>(XX)</u> this hospital) attended the deceased from <u>on 4/29/71</u> 19 <u>to</u> 19 <u>that (XX) (we) last saw the deceased alive on 4/29/71 at 4th</u> 19 <u>PM</u> and that <u>(XX)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(I) (We) (did) (did not) view the body after death.</u>							
23A. SIGNATURE <u>P. Seshachary MD</u>						23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>P. SESHACHARY MD</u>						23D. ADDRESS <u>Balto. City Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>5/3/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 3 1971</u>				25B. NAME OF REGISTRAR <u>2605</u>		25C. FUNERAL DIRECTOR <u>Schimunek Funeral Homes, Inc. 3331 Brehms</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-200 71 4210				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH X		REG. NO. 71 4210	
BIRTH NO.									
1. NAME OF DECEASED (Type or Print) WILLIAM H. BECK, JR					2. DATE AND HOUR OF DEATH 4-28-71 3:45 P M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. MARYLAND B&H Co. 5300				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE JOHNS HOPKINS HOSPITAL 33					C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
					E. STREET AND NUMBER 7401 PARK DRIVE				
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-8-08		9. AGE (In years last birthday) 62	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipe Fitter		10B. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Balto. Md.			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME WILLIAM BECK, Sr.					14. MOTHER'S MAIDEN NAME DOROTHY FORT Myrtle Padgett				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 213-10-9440		17. INFORMANT Mrs Dorothy Beck			ADDRESS Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.4 I CARDIO RESP. ARREST					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 23 days				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC ARREST x 4, CVA + renal ischemia				
					(B) DUE TO, OR AS A CONSEQUENCE OF: ASCVD				
					(C)				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION TRACHEOSTOMY 4-8-71			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED RESP INSUFFICIENCY			20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If not, medical examiner) NO			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) N/A			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) N/A			
21D. TIME OF INJURY (APPROX.) N/A			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR? N/A			
22. I certify that (1) (this hospital) attended the deceased from 4-1-71 to 4-28-71 that (1) (we) last saw the deceased alive on 4-28-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Steven E Rubin MD						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4-28-71	
23C. PHYSICIAN'S NAME (Type) STEVEN E RUBIN MD						23D. ADDRESS JOHNS HOPKINS HOSP., BALTIMORE, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5/3/71		24C. NAME OF CEMETERY OR CREMATORY Moreland Memorial		24D. LOCATION Balto Md		(State)	
25A. DATE REC'D BY HEALTH DEPT. MAY 2 1971			25B. NAME OF REGISTRAR Charles F. Evans			25C. FUNERAL DIRECTOR 8802 Hartford Rd			

THEY GO ON TO THE RIGHT

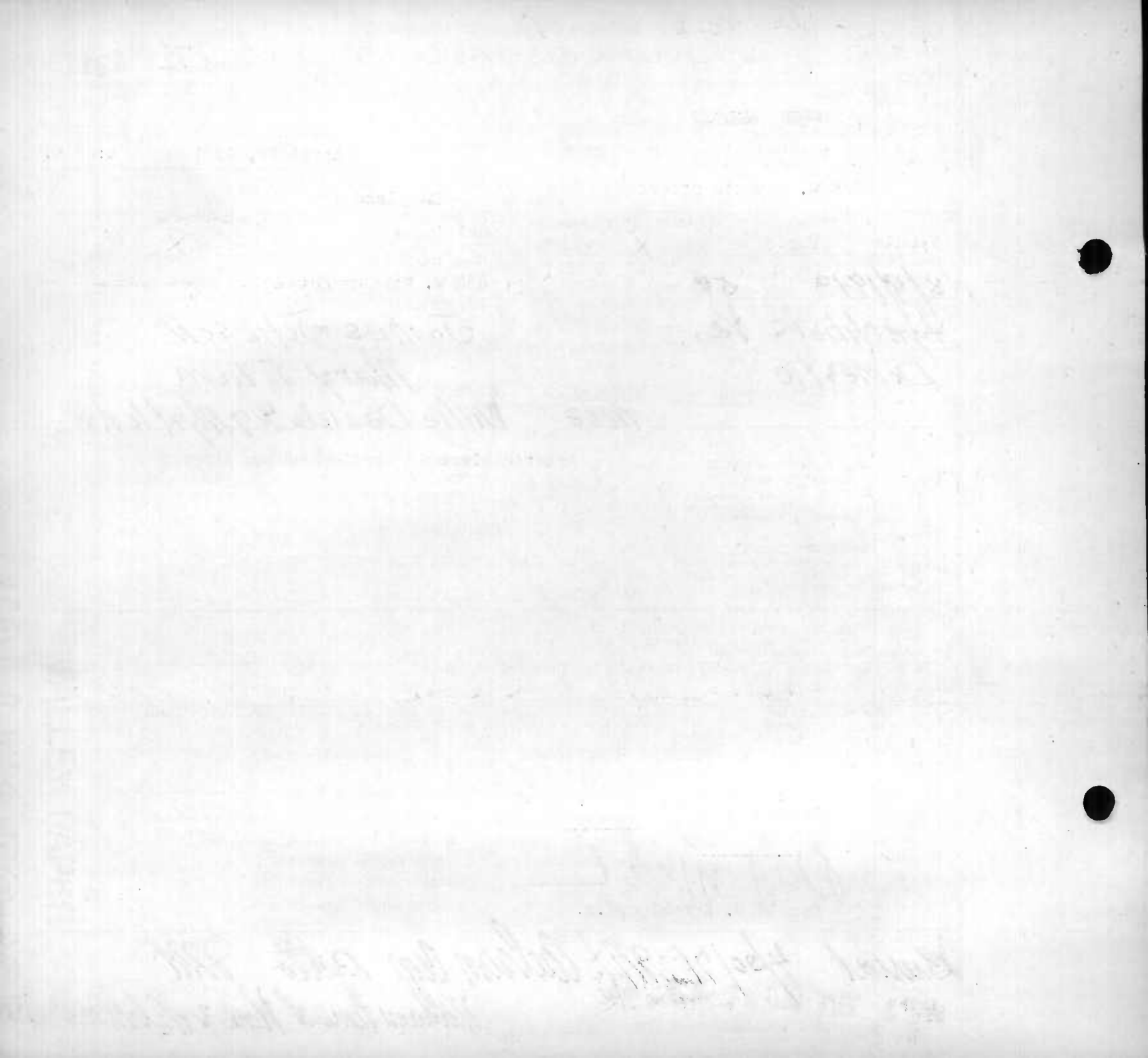
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THEY GO ON TO THE RIGHT

BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 71 4211	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) NANNIE NELSON			2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.		
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 838 W. Fayette Street			3. DATE PRONOUNCED DEAD Month Day Year Hour April 27, 1971 9:50 A.		
6. SEX Female			7. RACE Negro		
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			C. CITY OR TOWN Baltimore		
9. DATE OF BIRTH 8/9/1913			10. AGE (In years last birthday) 57		
11. BIRTH PLACE (State or foreign country) Lyndhurst, Va.			12. CITIZEN OF WHAT COUNTRY? James Johnson		
13. FATHER'S NAME James Johnson			14. MOTHER'S MAIDEN NAME Mary Elam		
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic			16. KIND OF BUSINESS OR INDUSTRY Domestic		
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			18. SOCIAL SECURITY NO. none		
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease			20. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic cardiovascular disease		
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Arteriosclerotic cardiovascular disease			22. DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic cardiovascular disease		
23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
25A. DATE OF OPERATION			26. CONDITION FOR WHICH OPERATION WAS PERFORMED		
27. AUTOPSY? (Yes or No) no			28. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		
29. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			30. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
31. TIME (Month) (Day) (Year) (Hour) (Approx.)			32. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
33. HOW DID INJURY OCCUR?			34. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		
35. ACTUAL SIGNATURE Ronald N. Kornblum, M.D.			36. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		
37. DATE SIGNED 4/27/71			38. DATE SIGNED		
39. BURIAL CREMATION, REMOVAL (Specify) Burial			40. DATE 4/30/71		
41. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery			42. LOCATION (City, town, or county) (State) Balto. Md.		
43. DATE REC'D BY HEALTH DEPT. MAY 3 1971			44. NAME OF REGISTRAR WILLIAMS Funeral Home		
45. FUNERAL DIRECTOR WILLIAMS Funeral Home			46. ADDRESS 319 N. Howard St.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

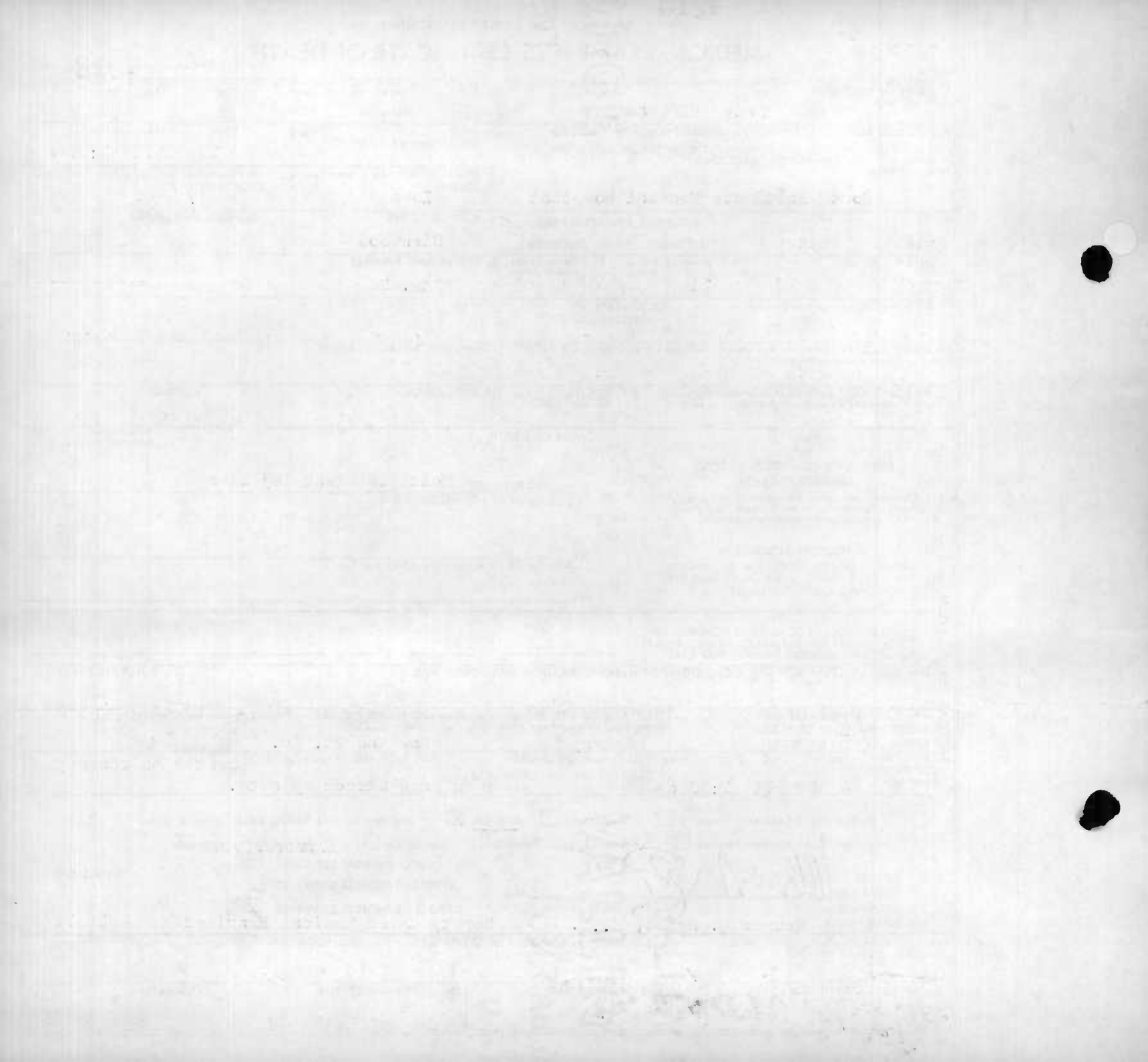
BIRTH NO. <u>C-435 71 4212</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>71 4212</u>	
1. NAME OF DECEASED (Type or Print) <u>COLTON Joseph</u>				2. DATE AND HOUR OF DEATH <u>4/30/71</u> <u>9:20 AM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>48 MGH</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md</u> B. COUNTY <u>2720</u>			
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>4011 Strathmore Ave, Apt B1</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/29/12</u>	9. AGE (in years last birthday) <u>59</u>	10. Under 1 Yr. Months Days Hours Min. 11. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Wm. H. Berger</u>		11. BIRTHPLACE (State or foreign country) <u>Russland md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Harry</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca</u>			
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>212-09-9265</u>		17. INFORMANT <u>Face sheet</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>MYOCARDIAL INFARCT</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ADTHEROSCLEROTIC HEART DISEASE</u>				CAUSE OF DEATH <u>MYOCARDIAL INFARCT</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ADTHEROSCLEROTIC HEART DISEASE</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>	
19. DATE OF OPERATION <u>4/10/71</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>DIABETES MELLITUS</u>			
20A. AUTOPSY? (Yes or No) <u>YES</u>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>4161</u>			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>4/30</u> 19 <u>71</u> to <u>4/30</u> 19 <u>71</u> and that (I) (we) last saw the deceased alive on <u>4/30</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Manojwala</u>				23B. DATE SIGNED <u>4/30/71</u>		23C. PHYSICIAN'S NAME (Type) <u>MANEJWALA</u>	
23D. ADDRESS <u>MGH</u>				23E. DEGREE <u>MD</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/2/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Hebrew Young Men</u>		24D. LOCATION (City, town, or county) (State) <u>Balto md</u>	
25A. DATE RECD BY HEALTH DEPT. <u>MAY 3 1971</u>				25B. FUNERAL DIRECTOR <u>Robert E. [unclear]</u>			
25C. ADDRESS <u>Robert E. [unclear]</u>				25D. ADDRESS <u>Sylvan Lewis & Son 9610 Reisterstown Rd</u>			

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO. 71 4213

1. NAME OF DECEASED (Type or Print) Dale Hindman		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 28 71 3:07 a M.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Iowa	
9. DATE OF BIRTH 23 June 1949		10. AGE (In years lost birthday) 21	
11. BIRTHPLACE (State or foreign country) Glenwood, Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Willard C. Hindman		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COAST GUARD	
15. MOTHER'S MAIDEN NAME Betty B.		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes 5 Aug 68 - 28 April 71	
17. SOCIAL SECURITY NO. 482-583624		18. INFORMANT USCG Base-Curtis Bay, Md.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) highway	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 4 28 71 2:35 a.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? beaten on roadway and struck by auto.		21. AUTOPSY? (Yes or No) yes	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner 4/28/71 DATE SIGNED			
24A. BURIAL-CREATION, REMOVAL (Specify)		24B. DATE May 3, 1971	
24C. NAME OF CEMETERY or CREMATORY Peterson F. H.		24D. LOCATION (City, town, or county) (State) Glenwood, Mills Iowa	
25A. DATE REC'D BY HEALTH DEPT. MAY 3 1971		25B. NAME OF REGISTRAR John F. [unclear]	
25C. FUNERAL DIRECTOR Robert Benavise, Severna Park, Md.		25D. ADDRESS	



BIRTH NO.

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 4214

1. NAME OF DECEASED (Type or Print) John P. Kelly (Kelley)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 28 71 7:20 a M.	
6. SEX male		7. RACE white	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Summerville	
9. DATE OF BIRTH 2-11-44		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) 27		E. STREET AND NUMBER 45 Bank St.	
11. BIRTHPLACE (State or foreign country) Boston, Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis W. Kelley		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter	
15. MOTHER'S MAIDEN NAME Mary P. Cassidy		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 012-34-5082		18. INFORMANT ADDRESS	
19. E 8/5/1		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Craniocerebral injury DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) highway	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? JFX 3 mi. north of Whitemarsh Blvd.		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 4 23 71 10:30 pm.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? passenger in auto which struck bridge column	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE [Signature] M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Werner H. Spitz, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-1-71	
24C. NAME OF CEMETERY OR CREMATORY Westview Cemetery		24D. LOCATION (City, town, or county) (State) Lexington, Massachusetts	
25A. DATE REC'D BY HEALTH DEPT. MAY 3 1971		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR John C. Miller Inc.		ADDRESS 415 Belair Rd. - 21206	

CALENDAR

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>W-300</u> <u>71</u> <u>4215</u>				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. <u>71</u> <u>4215</u>	
1. NAME OF DECEASED (Type or Print) WYATT, WALTER HENRY				2. DATE AND HOUR OF DEATH APRIL 27, 1971		11:55 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 20810 <u>6300</u>					
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229		(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN LAUREL		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER 152 N. WASHINGTON BLVD									
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/24/18	9. AGE (In years last birthday) 52	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MECHANIC			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CANTONI WYATT				14. MOTHER'S MAIDEN NAME EMMA KOHLHEIM					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W W 2			16. SOCIAL SECURITY NO. [REDACTED]		17. INFORMANT BALTO MD 21229 ADDRESS ST AGNES' RECORDS CATON & WILKENS AVES				
18. 16201 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Myocarditis with severe Heart failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Metastatic Ca Peritracheal				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (X) (this hospital) attended the deceased from APRIL 28 19 71 to APRIL 28 19 71 that (X) (we) lost saw the deceased alive on APRIL 28 19 71 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.									
23A. SIGNATURE A. Shams, M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4-28-71			
23C. PHYSICIAN'S NAME (Type) A. SHAMS,		MD. WILKENS & CATON AVE.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-1-71		24C. NAME of CEMETERY or CREMATORY MEADOW RIDGE MEM. PARK		24D. LOCATION (City, town, or county) ELK RIDGE		IS (State) MD.	
25A. DATE REC'D BY MONTH, DAY, YEAR MAY 3 1971		25B. NAME OF REGISTRAR [REDACTED]		25C. FUNERAL DIRECTOR Higginbotham, Shook		ADDRESS 1511 COTTAGE			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

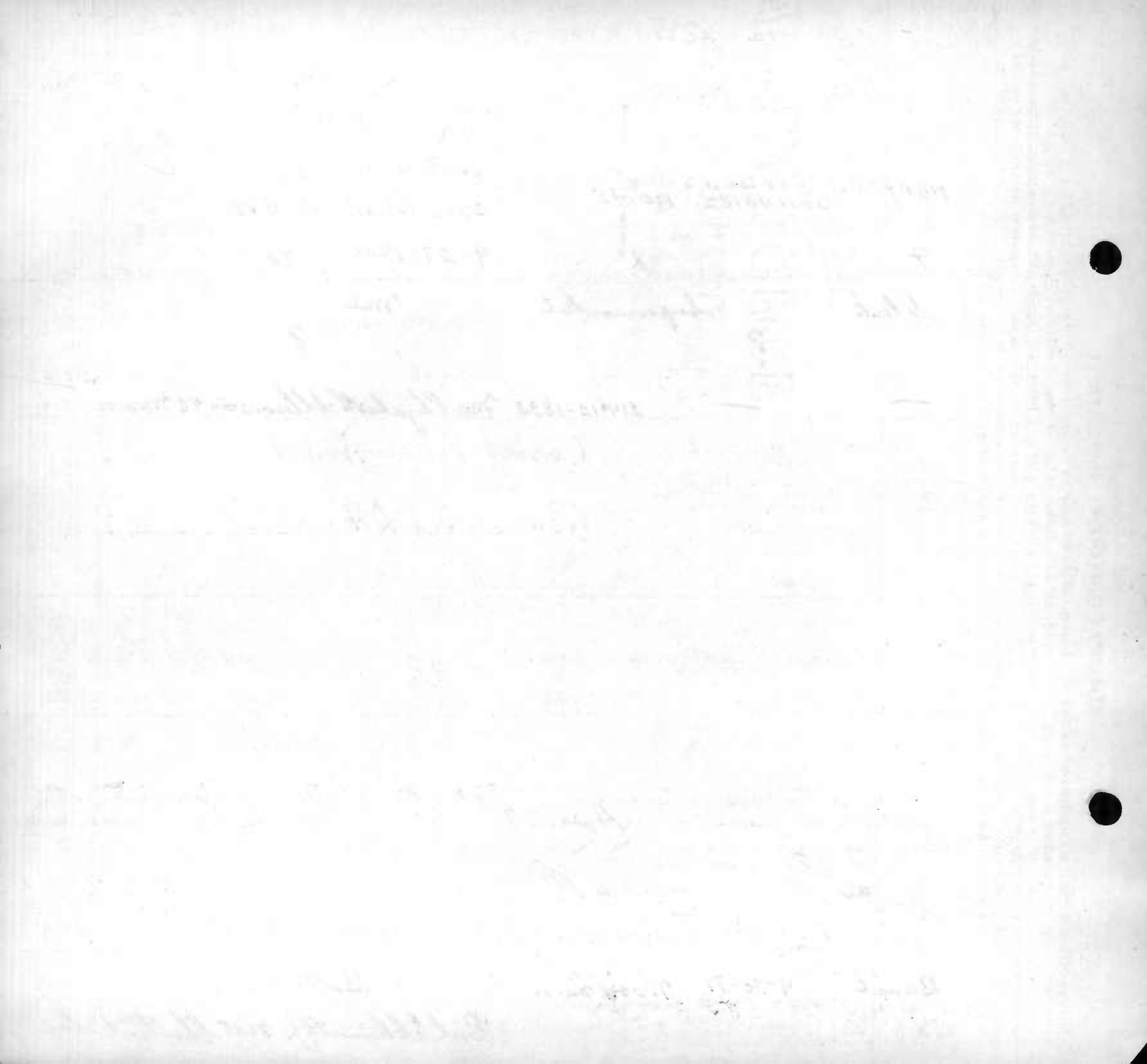
K-626		71 4216		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 4216	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Charles Krieser (Kraiser)</i>				2. DATE AND HOUR OF DEATH <i>4/29/71 12:15 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>md</i> B. COUNTY <i>2101</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>00 1015 Sterrett St.</i>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>male</i>		6. RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1/7/1903</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <i>Douglas Chemical</i>		9. AGE (In years last birthday) <i>68?</i>		11. BIRTHPLACE (State or foreign country) <i>unknown</i>	
13. FATHER'S NAME <i>unknown</i>				14. MOTHER'S MAIDEN NAME <i>unknown</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>yes 1/20/1920 - 6/7/1921</i>				16. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		17. INFORMANT <i>Thelma Krieser - 1015 Sterrett St - 21230</i>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Massive myocardial infarction, diabetes</i> <i>Post extensive abdominal surgery</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>4/10/71</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>1960</i> to <i>April 29</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>April 29</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Stanley Ankudis</i>				23B. DATE SIGNED <i>4.29.71</i>		23C. PHYSICIAN'S NAME (Type) <i>STANLEY ANKUDIS</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>5/3/71</i>		24C. NAME OF CEMETERY or CREMATORY <i>Green Haven Cem.</i>	
24D. LOCATION <i>Green Haven Md.</i>				25A. DATE REC'D BY HEALTH DEPT. <i>MAY 3 1971</i>			
25B. NAME OF REGISTRAR <i>John J. Lawrence</i>				25C. FUNERAL DIRECTOR <i>John J. Lawrence Inc.</i>			
25D. ADDRESS <i>1101 Maiden Choice La Balto 21209</i>				25E. ADDRESS <i>1101 Maiden Choice La Balto 21209</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
0-600 71 4217		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Bessie O'Hara</i>		2. DATE AND HOUR OF DEATH <i>4/28/71</i> <i>11:40 A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Harford Gardens Convales. Home</i>		A. STATE <i>MD.</i>		B. COUNTY <i>Balti.</i>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>BALTIMORE</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <i>1806 GIBBONS AVE.</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-27-1900</i>	9. AGE (In years last birthday) <i>70</i>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>clerk</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Supermarket</i>		11. BIRTHPLACE (State or foreign country) <i>Ind.</i>	
13. FATHER'S NAME <i>?</i>		14. MOTHER'S MAIDEN NAME <i>?</i>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>—</i>		16. SOCIAL SECURITY NO. <i>214-12-1832</i>		17. INFORMANT <i>Mrs Elizabeth Allison</i>	
				ADDRESS <i>21212</i> <i>5646 Woodmont Ave</i>	
18. <i>43691</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Cerebral Vascular Accident</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Generalized Arteriosclerosis</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A):					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Feb 18</i> 19 <i>71</i> to <i>Apr 28</i> 19 <i>71</i> , that (I) (we) last saw the deceased alive on <i>Apr 27</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <i>Loy M. Zimmerman M.D.</i>				23B. DATE SIGNED <i>4/29/71</i>	
23C. PHYSICIAN'S NAME (Type) <i>Loy M. Zimmerman M.D.</i>		23D. ADDRESS <i>3202 Harford Rd. Baltimore, Md</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4-30-71</i>		24C. NAME of CEMETERY or CREMATORY <i>Woodlawn</i>	
24D. LOCATION <i>Balto Co</i>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 3 1971</i>		25B. NAME OF REGISTRAR <i>Paul E. Zimmerman</i>		25C. FUNERAL DIRECTOR <i>Paul E. Zimmerman</i>	
				ADDRESS <i>3615 Chestnut Ave</i>	

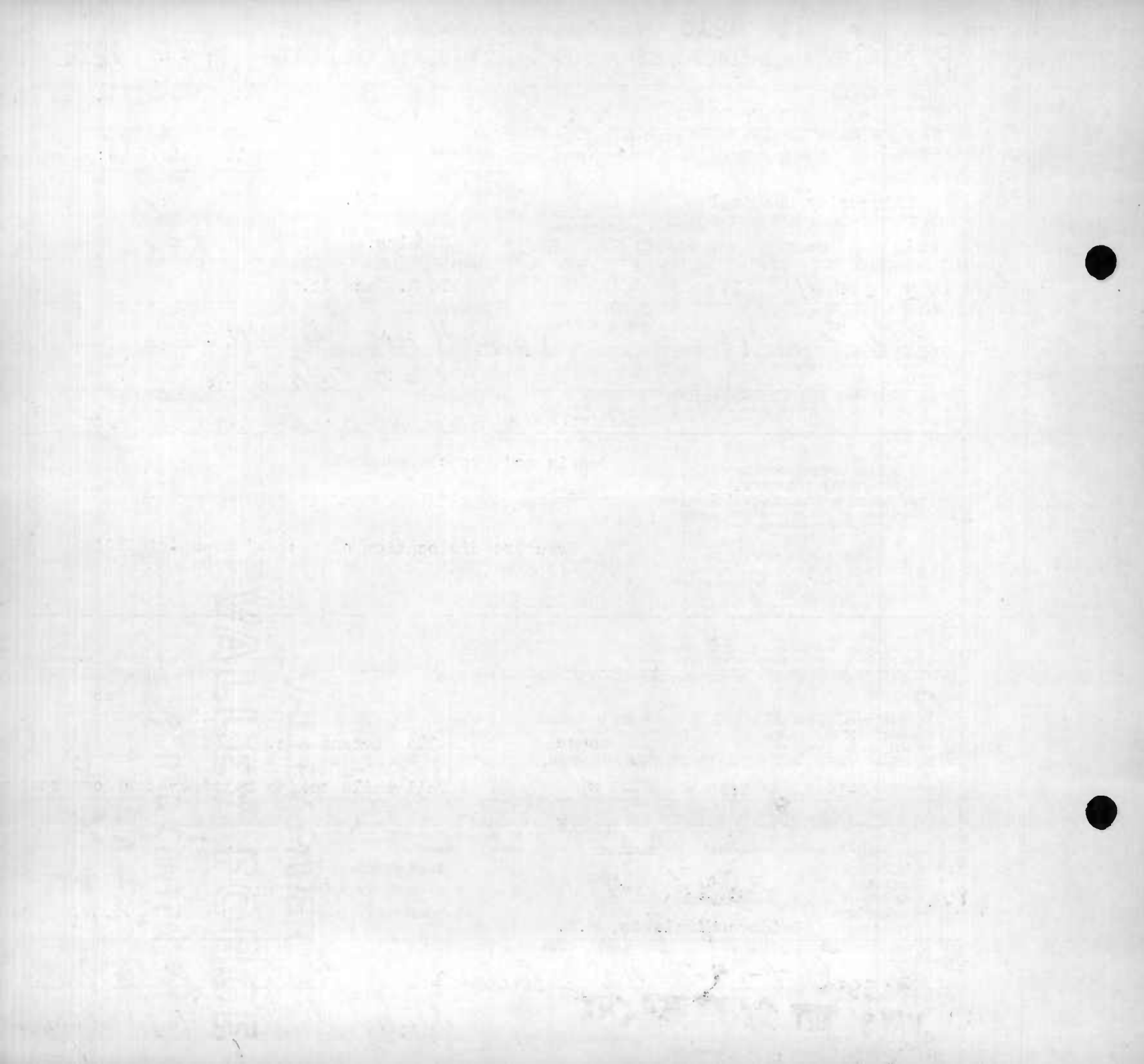


B-500

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED (Type or Print) ELROY BOONE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 4 11 1971 1:55 a M.	
6. SEX male		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED DIVORCED <input type="checkbox"/>	
7. RACE negro		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 12-27-41		10. AGE (In years lost birthday) 29	
11. BIRTHPLACE (State or foreign country) BALTO. MD.		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME Rose White	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 214-38-4146	
18. INFORMANT MURSAINE BOONE		ADDRESS 1013 STERRETT ST	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) E880X Sepsis and bronchopneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). fracture dislocation of neck with quadriplegia			
20A. DATE OF OPERATION 4-1-71		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) house	
22C. WHERE DID INJURY OCCUR? 333 Simtens Ave. 2004		22D. TIME OF INJURY (APPROX.) 4-1-71 2:30 p m.	
22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? Fell while taking refrigerator down stairs	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.		DATE SIGNED 4/11/71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-17-71	
24C. NAME OF CEMETERY or CREMATORY Westport Balto Md.		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. MAY 3 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Wesley Chavis Jr.		ADDRESS 1922 Elmwood	

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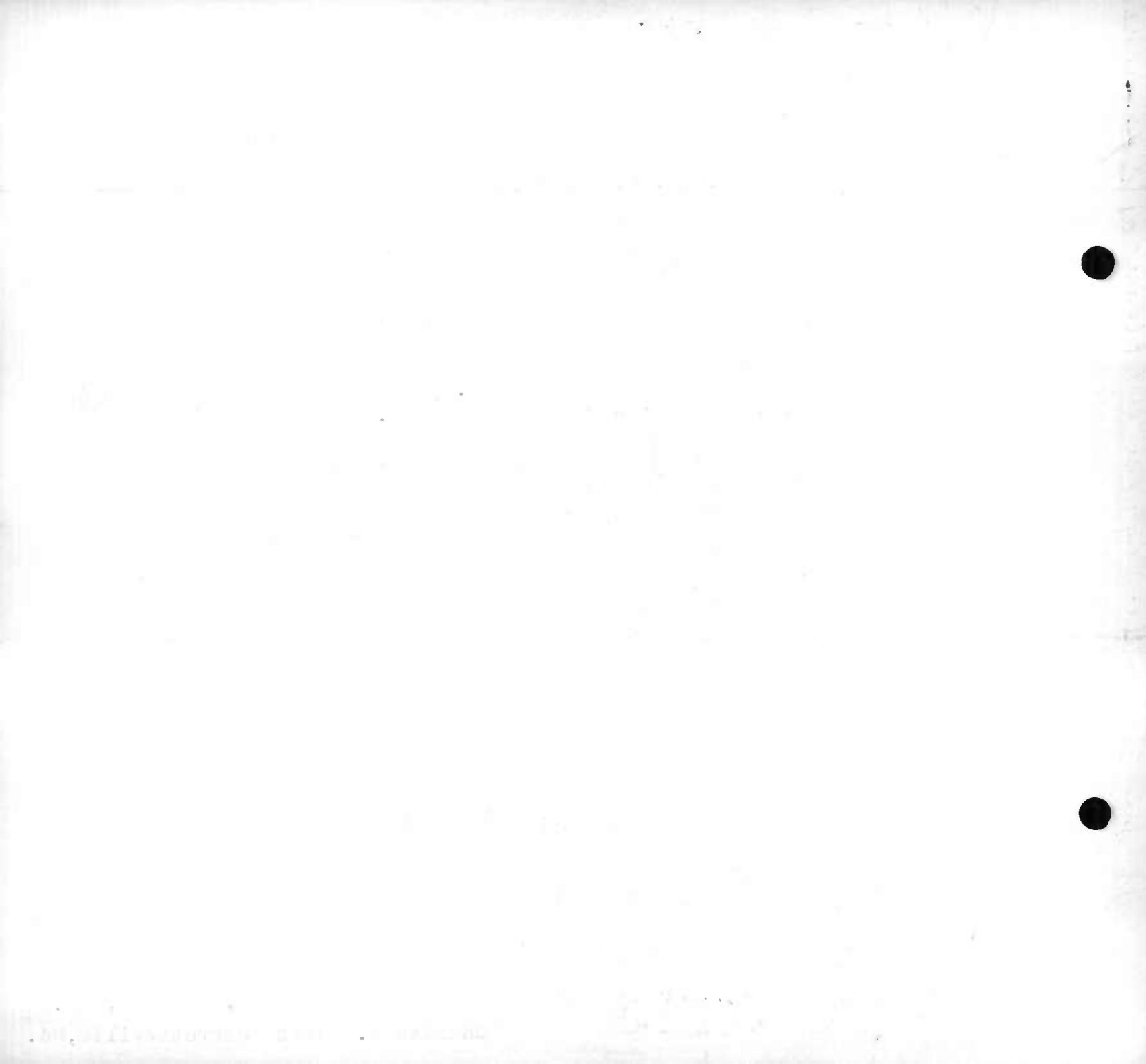


To be countersigned by Medical Examiner

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

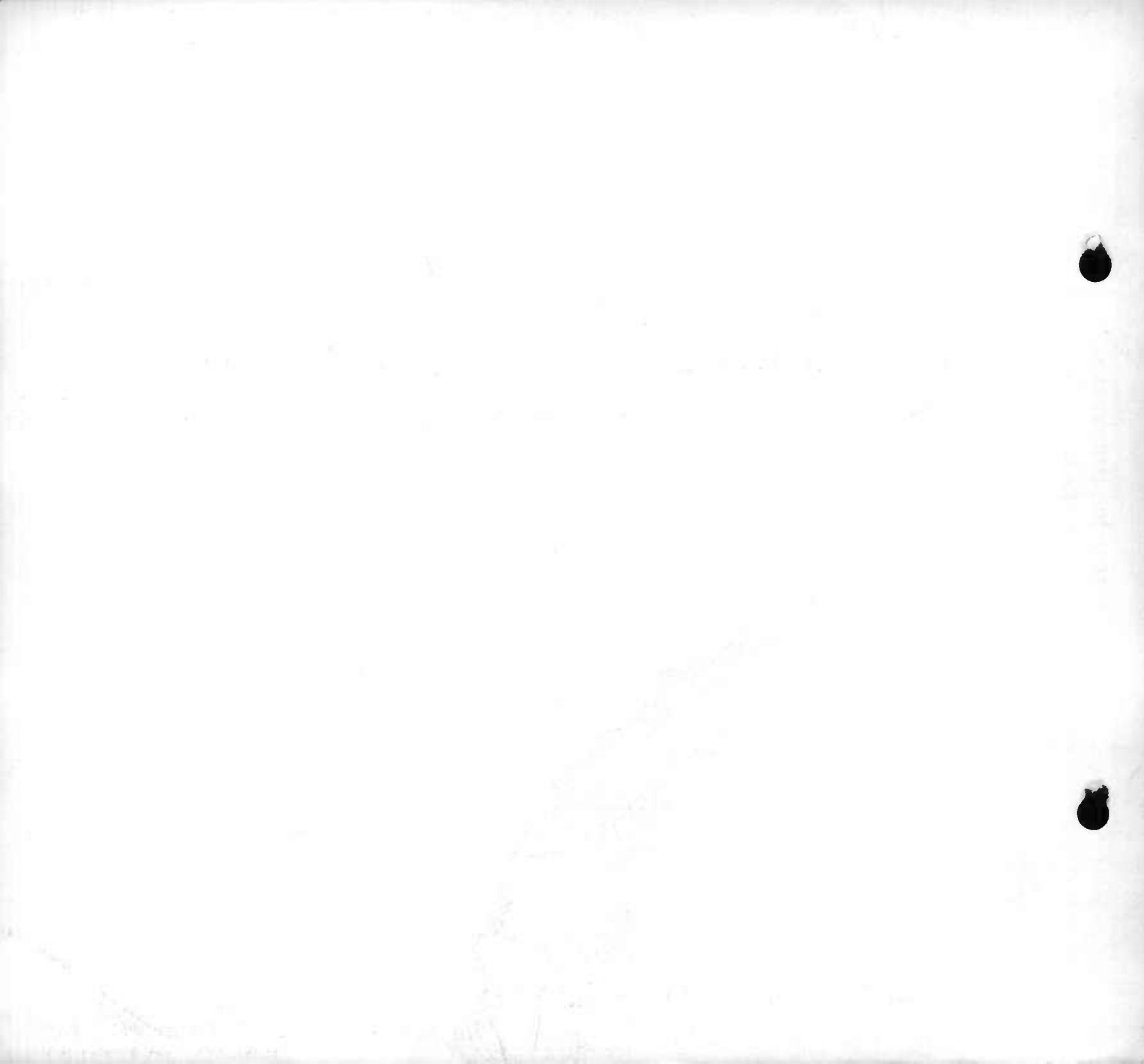
P-625 71 4219		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 4219	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Guy Leroy Perkins		2. DATE AND HOUR OF DEATH 4/29/71 12:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Harford			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Maryland General Hospital Fallston		C. CITY OR TOWN Fallston		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 2917 Nelson Lane					
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/26/04	9. AGE (In years last birthday) 66	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Va.	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME James Monroe Perkins		14. MOTHER'S MAIDEN NAME Della Hash			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-32-3606		17. INFORMANT Mrs. Zollic P. Perkins	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH A. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Atelectasis - marked B. MEDICATED OR UNDIFF. CAUSE DUE TO, OR AS A CONSEQUENCE OF: Medardadic undiff. Ca - source not determined C. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 21047		ADDRESS 2917 Nelson Lane Fallston, Md	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/12 to 4/29 1971 and that (I) (we) last saw the deceased alive on 4/29 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE George C. Samaras MD		23B. DATE SIGNED 4/29/71		23C. PHYSICIAN'S NAME (Type) George C. Samaras MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/3/1971		24C. NAME OF CEMETERY OR CREMATORY Upper Cross Roads Baptist	
24D. LOCATION Baldwin, Harford, Md.		24E. NAME OF REGISTRAR Charles E. Kurtz		24F. FUNERAL DIRECTOR Jarrettsville, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 3 1971		25B. NAME OF REGISTRAR Charles E. Kurtz		25C. FUNERAL DIRECTOR Jarrettsville, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>W-420</u> <u>71</u> <u>4220</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>71</u> <u>4220</u>	
1. NAME OF DECEASED (Type or Print) <u>David A Wallace</u>				2. DATE AND HOUR OF DEATH <u>4-29-71</u> <u>2</u> <u>PM</u> <u>M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Univ of Maryland Hospital</u>				A. STATE <u>Md</u>		B. COUNTY <u>21223</u> <u>1902</u>	
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>1307 Kuper Place B</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>9-24-03</u>	9. AGE (In years last birthday) <u>67</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>HOUSEHOLD APPLIANCES</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>LEVIN WALLACE</u>			
14. MOTHER'S MAIDEN NAME <u>MARTHA CREAMER</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>215-09-1973</u>				17. INFORMANT <u>WM. WALLACE</u> ADDRESS <u>Route 3, BEACHMONT, DR. 3YKCSVILLE MD. 21784</u>			
18. <u>4-29-71</u> <u>17-23-07</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Entrenched hemorrhage (patent)</u> <u>12 hr</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <u>Hypertensive Cardiovascular disease</u> <u>?</u>			
				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Diabetes mellitus</u>							
19A. DATE OF OPERATION <u>4-29-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Entrenched hemorrhage</u>		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>4-28</u> 19 <u>71</u> to <u>4-29</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>4-29</u> 19 <u>71</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Paul R. Schuch</u> <u>MO</u>				23B. DATE SIGNED <u>4-29-71</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <u>Univ of Md Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>5/3/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>ORIOLE CEMETERY</u>		24D. LOCATION (City, town, or county) (State) <u>ORIOLE, SOMERSET Co. Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 3 1971</u>		25B. NAME OF REGISTRAR <u>Robert A. Sisk</u>		25C. FUNERAL DIRECTOR <u>W. FIALKOWSKI</u>		ADDRESS <u>2007 EASTERN AVE. BALTO. MD. 21201</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4221	
S-263 71 4221		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Lawrence Sigwart		4-30-71 8:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital			A. STATE Maryland		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER Walker Ave. #21212		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-23-44	9. AGE (In years last birthday) 26	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tire Salesman		10B. KIND OF BUSINESS OR INDUSTRY Jerry's Tires	11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Gerard B. Sigwart			14. MOTHER'S MAIDEN NAME Marie Bach		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-46-4200	17. INFORMANT Mrs Sharon Sigwart		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Metastatic disease 2 nd to melanoma.		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ariel Solis M.D.			23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) ARIEL SOLIS M.D.
23D. ADDRESS					
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		5-4-1971		Parkwood Cemetery	
24D. LOCATION (City, town, or county) (State)		Taylor Ave Balto, Md			
25A. DATE REC'D BY HEALTH DEPT.		25B. FUNERAL DIRECTOR		25C. ADDRESS	
MAY 9 1971		Frederick J. Cook		7200 Harford Road	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>71 4222</u>	
<p><u>W-200 71 4222</u></p> <p>BIRTH NO.</p>		<p>1. NAME OF DECEASED (Type or Print) <u>Joseph P. Wask</u></p>		<p>2. DATE AND HOUR OF DEATH <u>May 1, 1971 12:30 A.M.</u></p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>35 Church Home & Hospice</u></p>				<p>4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2-02</u></p> <p>C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>13 S. Ann St</u></p>			
<p>5. SEX <u>MALE</u></p>		<p>6. RACE <u>WHITE</u></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>SEPT 18 1918</u></p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAILOR</u></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY <u>TAILOR SHOP</u></p>		<p>11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>	
<p>13. FATHER'S NAME <u>JOHN WOSIK</u></p>				<p>14. MOTHER'S MAIDEN NAME <u>JULIANNA CZYZA</u></p>			
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>YES</u> If yes, give war or dates of service <u>WORLD WAR II</u></p>		<p>16. SOCIAL SECURITY NO.</p>		<p>17. INFORMANT ADDRESS <u>JOANNE DEVESE LEIDEN RD 2120C</u></p>			
<p>18. <u>2910 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Pneumonia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Delirium Tremens</u> <u>Chronic Alcoholism, possible liver cirrhosis</u></p>				<p>CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>			
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>							
<p>19A. DATE OF OPERATION <u>0</u></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No)</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (Indify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>			
<p>22. I certify that (I) (this hospital) attended the deceased from <u>4/24</u> 19<u>71</u> to <u>5/1</u> 19<u>71</u> that (I) (we) last saw the deceased alive on <u>5/1</u> 19<u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>							
<p>23A. SIGNATURE <u>A.C. Chouvalit, M.D.</u></p>				<p>23B. DATE SIGNED <u>5/1/71</u></p>		<p>23C. PHYSICIAN'S NAME (Type) <u>A.C. CHOUVALIT, M.D.</u></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u></p>		<p>24B. DATE <u>MAY 4 1971</u></p>		<p>24C. NAME of CEMETERY or CREMATORY <u>HOLY ROSARY CEM.</u></p>		<p>24D. LOCATION (City, town, or county) (State) <u>GERMAN HILL RD BALTO MD</u></p>	
<p>25A. DATE REC'D BY HEALTH DEPT.</p>		<p>25B. NAME OF REGISTRAR <u>R. E. Faber, M.D.</u></p>		<p>25C. FUNERAL DIRECTOR ADDRESS <u>DIPPEL BROS INC 1800 E LOMBARD ST</u></p>			

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 4223

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LUCY M. TAYLOR		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1314 N. Central Ave.		3. DATE PRONOUNCED DEAD Month Day Year May 1, 1971 1:15 A.M.	
6. SEX Female		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 909	
7. RACE Negro		C. CITY OR TOWN Baltimore	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 7/3/06		E. STREET AND NUMBER 1314 N. Central Ave.	
10. AGE (In years last birthday) 64		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Henry Taylor	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Julia		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. 219-18-4031		18. INFORMANT Mrs Holland, Webb Court	

19. CAUSE OF DEATH 571.8 I		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Fatty metamorphosis of liver DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	

20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	

23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Charles S. Springate</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		5-1-71	
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					

24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/6/71		24C. NAME of CEMETERY or CREMATORY Mt Auburn C metry		24D. LOCATION (City, town, or county) (State) Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT. MAY 3 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR A Halstead 1206 W North Ave			

Letter from M.E.'s office

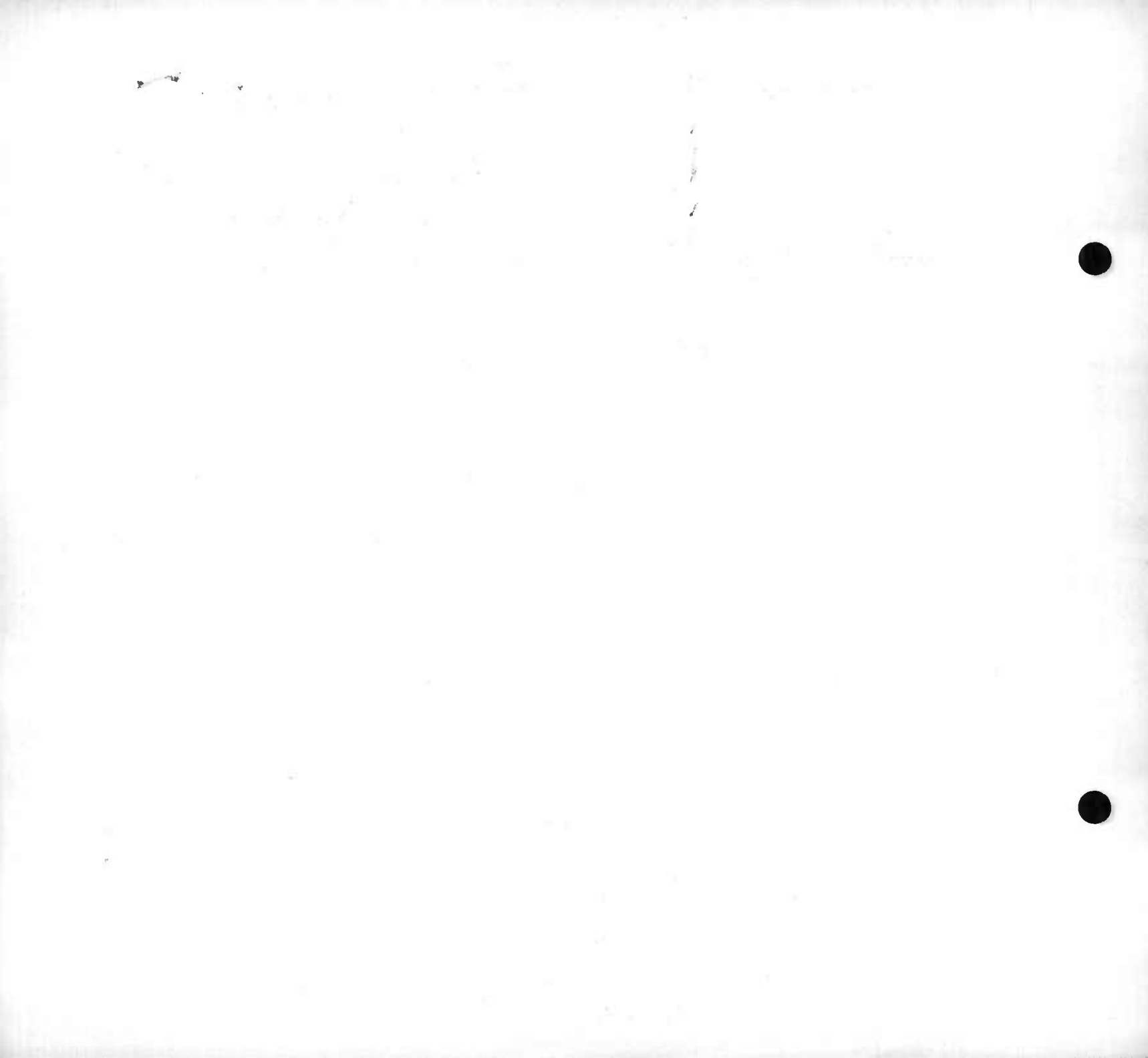
6-1-71 M.H.

VALLEY-SPR
VALLEY FORD SE
JOY HIG SCHOOL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 4224</u>	
<div style="display: flex; justify-content: space-between;"> <u>S-530 71 4224</u> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>PAT ANN SMITH</u>		2. DATE AND HOUR OF DEATH <u>23 APRIL 1971 10⁴⁰ P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 University Hospital</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE <u>Maryland</u>		B. COUNTY <u>1803</u>
			C. CITY OR TOWN <u>Baltimore</u>		
			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER <u>7 S Poppleton St.</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>10/18/31</u>	9. AGE (In years last birthday) <u>39</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>Alexander Smith</u>			14. MOTHER'S MAIDEN NAME <u>Bertha</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
<div style="display: flex;"> <div style="flex: 1;"> <p>18. <u>614X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="flex: 1;"> <p>CAUSE OF DEATH</p> <p>(A) IMMEDIATE CAUSE <u>generalized peritonitis</u> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) <u>ruptured tubo-ovarian abscess</u> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p> </div> <div style="flex: 0.5;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>6 days</u></p> </div> </div>					
<p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
19A. DATE OF OPERATION <u>34/19/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>peritonitis</u>		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/20</u> 19 <u>71</u> to <u>4/23</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>4/23</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>David W. Fricke MD</u>				23B. DATE SIGNED <u>4/23/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>David W. Fricke MD</u>				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/30/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Crest Lawn Cemetery</u>	
24D. LOCATION <u>Baltimore Md</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 3 1971</u>		25B. NAME OF REGISTRAR <u>Adolphus Halstead</u>		25C. FUNERAL DIRECTOR <u>Adolphus Halstead 1206 W North Ave</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4225	
BIRTH NO. 17-200		71 4225		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) George Mozie			2. DATE AND HOUR OF DEATH 4/29/71 2:20 p. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Bolton Hill Nursing Home 1400 John Street Baltimore, Maryland 21217			A. STATE B. COUNTY 2329 Eutaw Place Balto., Md. (17)		
5. SEX Male			6. RACE		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 6/6/06		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			9. AGE (in years last birthday) 67		
10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)		
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY? U.S.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no at unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 198-05-0686		
17. INFORMANT Chart,			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4/71		
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)			(A) IMMEDIATE CAUSE cerebral embolism with paralytic left		
			(B) DUE TO OR AS A CONSEQUENCE OF: Diabetes mellitus		
			(C) DUE TO OR AS A CONSEQUENCE OF: congestive heart failure		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/17 1971 to 4/29 1971		that (I) (we) lost saw the deceased alive on 4/29 1971		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE			23B. DATE SIGNED 4/30/71		
23C. PHYSICIAN'S NAME (Type) ALAN H. MAHEIT MD			23D. ADDRESS 2 E. Pearl St. Balto. 21202		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/3/71		24C. NAME OF CEMETERY OR CREMATORY MT Auburn Cemetry	
24D. LOCATION (City, town, or county) Baltimore, Md		25A. DATE REC'D BY HEALTH DEPT. MAY 3 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR A Halstead		25D. ADDRESS 1206 W N orth Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 71 4226				CITY HEALTH DEPARTMENT		REG. NO. 71 4226	
1. NAME OF DECEASED (Type in Print) John PRESTON DUNAWAY				2. DATE AND HOUR OF DEATH 4/29/71 at 6:15 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE md B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital, 6730 Ashburton St., Baltimore, Md 21216		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-10-80	
9. AGE (In years last birthday) 91		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) Va		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Thomas Dunaway				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unk		16. SOCIAL SECURITY NO. 219-03-0753A		17. INFORMANT ADDRESS Nettie Dunaway 1657 Vincent Ct.			
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) HEMOPHTYSIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. G.I. Carcinoma				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45 minutes			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/28/1971 to 4/29/1971 that (I) (we) last saw the deceased alive on 4/29/1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Azad Cader				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 4/29/71	
23C. PHYSICIAN'S NAME (Type) AZAD CADER				23D. ADDRESS Lutheran Hospital, Baltimore, Md 21216			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/3/71		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 3 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Kelson F.H. 1348 N. Calhoun St.			



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71 4227

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 4227

BIRTH NO.

1. NAME OF DECEASED (Type or Print) CYNTHIA M. VAUGHN				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 100 Rebird Avenue (Playground)				3. DATE PRONOUNCED DEAD Month Day Year Hour May 1, 1971 11:45 P.M.			
6. SEX Female				7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 10-15-55				10. AGE (In years lost birthday) 15		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF U.S.A.				13. FATHER'S NAME Cornelius Monroe		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2562	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no			
17. SOCIAL SECURITY NO.				18. INFORMANT Marie Vaughn			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 2966 X Stabwounds of neck and face				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) Yes							
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ?			
22C. WHERE DID INJURY OCCUR? ?				22D. TIME OF INJURY (Approx.) Month Day Year Hour ?			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				22F. HOW DID INJURY OCCUR? Stabbed and beaten by unknown assailant			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED May 2, 1971							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-6-71		24C. NAME of CEMETERY or CREMATORY New Cathedral Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 3 1971 Robert E. Taylor, M.D.				25B. NAME OF REGISTRAR Kelson F.H.			
25C. FUNERAL DIRECTOR V. Bailey				25D. ADDRESS 1348 Calhoun Street			

WALLLEY BOILING
WALLLEY BOILING

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-663 71 4228		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 4228	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) John Henry Ehrhardt		2. DATE AND HOUR OF DEATH 4-30-71 2 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. 2712 B. COUNTY		C. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 413 E. Lake Ave.	
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-6-03	9. AGE (In years last birthday) 67	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Semi-Retired		10B. KIND OF BUSINESS OR INDUSTRY Paper Supply Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John H. Ehrhardt, Sr.		14. MOTHER'S MAIDEN NAME Gertrude Wade	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service no		16. SOCIAL SECURITY NO. 215-07-2774		17. INFORMANT Mr. Dyson P. Ehrhardt	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.9 I Myocardial infarction		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASHD		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: Emphysema		Years	
(C)				Years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Indicate medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from June 2 1969 to Apr 30 1971 that (1) (we) last saw the deceased alive on Mar 23 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE RK Country		23B. DATE SIGNED 5-3-71		23C. PHYSICIAN'S NAME (Type) Dr. Richard K. Gundry M. D.	
23D. ADDRESS 2 W. University Pkwy.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-3-71	
24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. MAY 3 1971	
25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR H.W. Jenkins Sons Co.		25D. ADDRESS 4905 York Rd. Baltimore, Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4229	
<div style="display: flex; justify-content: space-between;"> H-416 71 4229 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
NED (NATHAN) HALPERT		APRIL 29, 1971 5/35 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 00 PARK TOWERS WEST, APT. 205 7121 PARK HEIGHTS AVENUE		A. STATE MARYLAND			
		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 7121 PARK HEIGHTS AVENUE, APT. 205			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 25, 1905	9. AGE (In years last birthday) 65	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRESIDENT		10B. KIND OF BUSINESS OR INDUSTRY AL-LON MFG. CO.		11. BIRTHPLACE (State or foreign country) RUSSIA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME LOUIS HALPERT			
14. MOTHER'S MAIDEN NAME BELLE KAMSKY		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MRS. LILLIAN HALPERT, 7121 PARK HGHTS. AVE. #15			
18. CAUSE OF DEATH					
<div style="display: flex;"> <div style="flex: 1;"> <p>I</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="flex: 1;"> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: metastatic Carcinoma of Lung.</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p> </div> <div style="flex: 1;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>					
<p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Nat White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/1970 to 4/29/71 , that (I) (we) last saw the deceased alive on 4/29/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE 		23B. DATE SIGNED 4/30/71		23C. PHYSICIAN'S NAME (Type) LEONARD LISTER	
23D. ADDRESS 7111 PARK HEIGHTS AVENUE		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			
24B. DATE 4-30-71		24C. NAME OF CEMETERY or CREMATORY BALTIMORE HEBREW		24D. LOCATION (City, town, or county) (State) REISTERSTOWN, MD MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. MAY 3 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	

Antelope Canyon

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4/20/17

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4230	
71 4230				CERTIFICATE OF DEATH	
BIRTH NO. 8-251		1. NAME OF DECEASED (Type or Print) HENRY ROSENBERG		2. DATE AND HOUR OF DEATH APRIL 30, 1971 9:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2719		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION PLEASANT MANOR NURSING HOME 4615 PARK HEIGHTS AVENUE		E. STREET AND NUMBER 4017 GLEN AVENUE			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10B. KIND OF BUSINESS OR INDUSTRY RETAIL		11. BIRTHPLACE (State or foreign country) RUSSIA BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME MEYER ROSENBERG		14. MOTHER'S MAIDEN NAME DORA K COLEMAN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. II ARMY		16. SOCIAL SECURITY NO. 212-16-9134		17. INFORMANT MR. JACK ROSENBERG, 4017 GLEN AVENUE	
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Cardiac Arrest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH min.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Arteriosclerotic cardiovascular disease (C).....			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-4-69 19 to 4-30-71 19, that (I) (we) last saw the deceased alive on 4-27-71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Frank G. Kuehn</i>		23B. DATE SIGNED 4-30-71		23C. PHYSICIAN'S NAME (Type) FRANK G. KUEHN	
23D. ADDRESS 21 MEDICAL ARTS BLDG.		23E. DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-30-71		24C. NAME of CEMETERY or CREMATORY CHOFETZ CHAIM	
24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. MAY 3 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD		25D. ADDRESS			

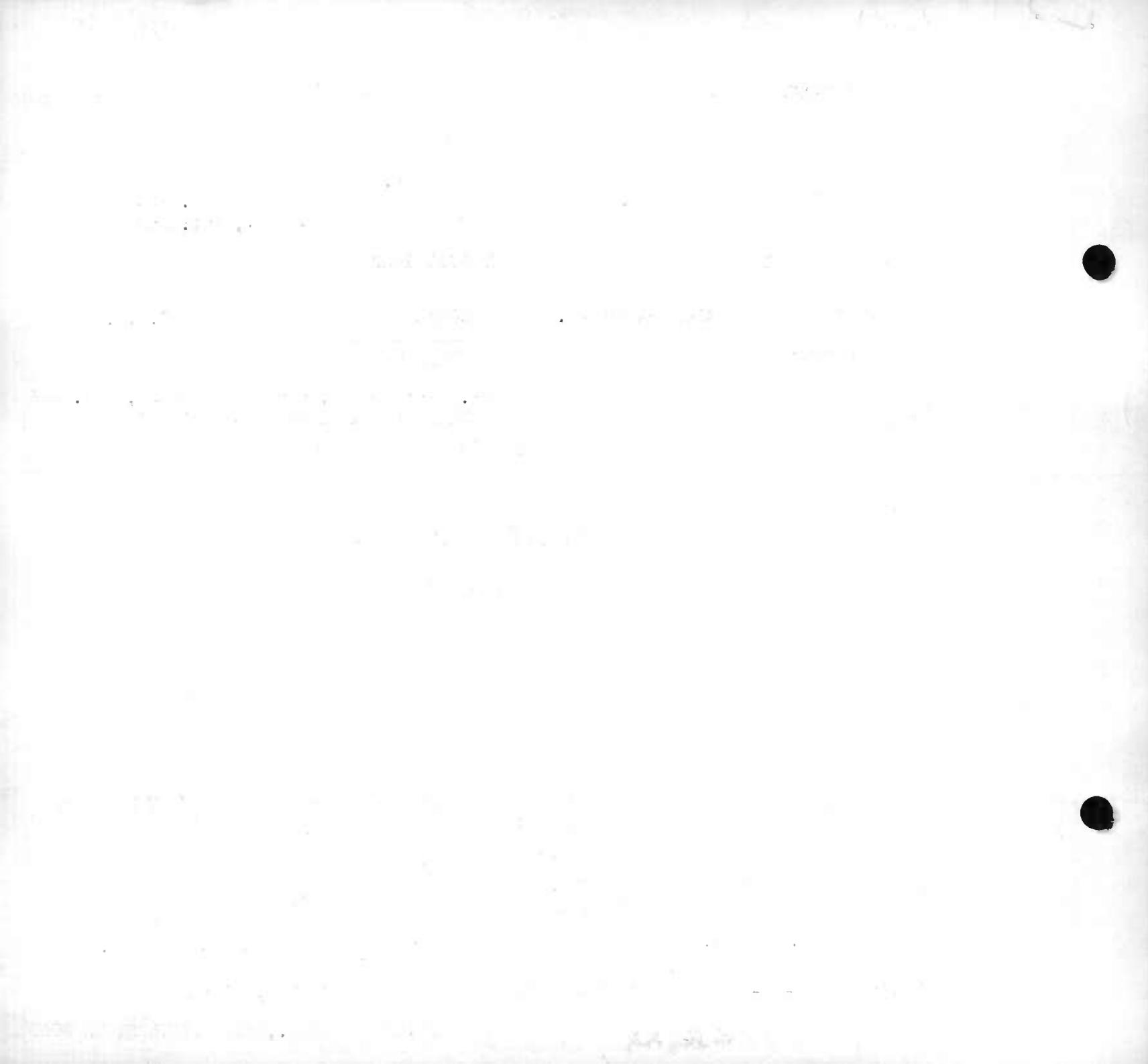
ALPHABETICALLY

INDEX

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 4231</u>
BIRTH NO. <u>C-160</u>		DATE AND HOUR OF DEATH <u>4/29/71 1:10 p.m.</u>		
1. NAME OF DECEASED (Type or Print) <u>Alexander Cooper</u>		2. DATE AND HOUR OF DEATH		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>37 Mercy Hospital, Inc.</u>		A. STATE <u>Md</u> B. COUNTY <u>2730</u>		
5. SEX <u>MALE</u>		C. CITY OR TOWN <u>Balto.</u>		
6. RACE <u>WHITE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <u>7121 Park Heights Ave., APT. 303</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>auctioneer</u>		9. AGE (in years last birthday) <u>69</u>		
10B. KIND OF BUSINESS OR INDUSTRY <u>ALEX COOPER CO.</u>		11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>		
13. FATHER'S NAME <u>JOSEPH COOPER</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		14. MOTHER'S MAIDEN NAME <u>XXX BELLE ?</u>		
16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. MARY COOPER, PARK TOWERS WEST, APT. 303</u> <u>7121 PARK HEIGHTS AVENUE #21215</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Acute Myocardial Infarction</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				
(B) <u>Gastric Ulcer -</u> DUE TO, OR AS A CONSEQUENCE OF:				
(C) <u>Moderate B.I. Hemorrhage.</u>				
19. DATE OF OPERATION <u>2</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. HOW DID INJURY OCCUR?		
21F. HOW DID INJURY OCCUR?				
22. I certify that (H) (this hospital) attended the deceased from <u>4/29</u> 19 <u>71</u> to <u>4/29</u> 19 <u>71</u> that (W) (we) last saw the deceased alive on <u>4/29</u> 19 <u>71</u> and that (M) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Patrick A. Molony, MD</u>		23B. DATE SIGNED <u>4/29/71</u>		
23C. PHYSICIAN'S NAME (Type) <u>Patrick A. Molony, MD</u>		23D. ADDRESS <u>Mercy Hospital 301 St. Paul Pl.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4-30-71</u>		24C. NAME of CEMETERY or CREMATORY <u>HEBREW YOUNG MEN</u>
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>
25D. LOCATION <u>BALTIMORE, MARYLAND</u>		25E. ADDRESS <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO.	
S-346		71		4232		71 4232	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
SEIDLER SARA				4/28/71 7:50 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 SINAI HOSP OF BALTO., INC.				A. STATE		B. COUNTY	
				MARYLAND		5300	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				BALTIMORE		YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				7906 DUNHILL VI. CIRCLE # 7			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Hours
FEMALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8/13/97	73			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
BOOKKEEPER				OFFICE MGR.		RUSSIA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
HYMAN SEIDLER				REBECCA SHOR			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
NO				212-01-3451A		MRS. ANN JOSEPH 7906 DUNHILL VILLAGE CIR. APT. 202	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		① Pneumonia @ Hyponatremia 6 days	
				(B) CVA DUE TO, OR AS A CONSEQUENCE OF:		6 days	
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(APPROX.)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 4/23/19 71 to 4/28/19 71 that (I) (we) last saw the deceased alive on 4/28/19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Vicki Atichartakarn, M.D.				4/28/71			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
VICKI ATICHARTAKARN, M.D.				SINAI HOSP. OF BALTO., INC.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		4-30-71		BETH TFILOH		BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAY 3 1971		R. E. Taylor, Jr.		SOL LEVINSON & BROS.		6010 REISTERSTOWN ROAD	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 4233

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

HORACE PITTMAN

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00636 Eisle Street

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

April 29, 1971

7:00 P.M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

2101

6. SEX

Male

7. RACE

Negro

8. MARRIED

☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

9/15/04

10. AGE (In years
last birthday)

66

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

636 Eisle Street

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF

U.S.A.

13. FATHER'S NAME

Joshua Pittman

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Rose

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL
SECURITY NO.

705-12-5461

18. INFORMANT

ADDRESS

Bessie Pittman 776 Carroll St.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S

NAME (Type) Werner U. Spitz M.D. Deputy Chief Medical Examiner

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/30/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

5/3/71

24C. NAME of CEMETERY or CREMATORY

Mt. Auburn

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

MAY 3 1971

25B. NAME OF REGISTRAR

Robert E. Farber, M.D.

25C. FUNERAL DIRECTOR

Charles A. Rice

ADDRESS

661 W. Barre St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 4234	
4-610 71 4234		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Harvey, Mattie		2. DATE AND HOUR OF DEATH 4/30/71 11 45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital of Maryland 46		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1608 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 610 N. Denison St.	
5. SEX Female	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-20-25
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) 45
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Chart RAYMOND HARVEY 610 N. DENISON ST.		ADDRESS	
18. 153.11		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Ca Transverse Colon		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Ca Transverse Colon		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Nil			
19A. DATE OF OPERATION 03/15/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca Left Transverse Colon	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) Nil		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Nil	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Nil		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) Nil	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? Nil	
22. I certify that (I) (this hospital) attended the deceased from 3-3-1971 to 4-30-1971 that (I) (we) last saw the deceased alive on 4-30-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE J. Samuel (JASON SAMUEL)		23B. DATE SIGNED 4-30-71	
23C. PHYSICIAN'S NAME (Type) Dr. E. Walden		23D. ADDRESS 4200 Edmondson Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-5-71	
24C. NAME OF CEMETERY OR CREMATORY CEDAR HILL		24D. LOCATION (City, town, or county) (State) JOHNSONVILLE, S. CAROLINA	
25A. DATE REC'D BY HEALTH DEPT. MAY 9 1971		25B. NAME OF REGISTRAR R. E. Taylor, M.D.	
25C. FUNERAL DIRECTOR CHARLES A. RICE		ADDRESS 661 W. BARRE ST.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4235	
7-460		71 4235		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>ELIZABETH EMMA LOU FULLER</u>		2. DATE AND HOUR OF DEATH <u>5/2/71</u> <u>12 25 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>BON SECOURS HOSPITAL</u>		A. STATE <u>MD</u>		B. COUNTY <u>605</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>1500 W. Fayette ST</u>			
5. SEX <u>50 F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/18/20</u>	9. AGE (In years last birthday) <u>51</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Coalbrook, Pa</u>	
12. FATHER'S NAME <u>William Grady</u>		13. MOTHER'S MAIDEN NAME <u>Pearl Ewell</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Henry Fuller - 1500 W. Fayette ST</u>	
18. <u>4/12/71</u> <u>12 25 09</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pulmonary edema</u>		<u>hours</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Consecutive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>months</u>	
		(C) <u>Hypertensive + Arteriosclerotic Ht. Disease</u>		<u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>Diabetes Mellitus</u>		<u>years</u>	
19A. DATE OF OPERATION <u>2</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>Yes</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that <u>NY</u> (this hospital) attended the deceased from <u>5/1</u> 19 <u>71</u> to <u>5/2</u> 19 <u>71</u> that <u>NY</u> (we) last saw the deceased alive on <u>5/2</u> 19 <u>71</u> and that <u>NY</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>NY</u> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Samuel A. Rumack M.D.</u>		23B. DATE SIGNED <u>5/2/71</u>			
23C. PHYSICIAN'S NAME (Type) <u>RUMACK</u>		23D. ADDRESS <u>Bon Secours Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>5/6/71</u>	24C. NAME OF CEMETERY or CREMATORY <u>Mt Auburn</u>		24D. LOCATION (City, town, or county) (State) <u>Balto.</u> <u>MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 3 1971</u>	25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	25C. FUNERAL DIRECTOR <u>Purnell B. Odum</u>		ADDRESS <u>106 E. Light Ave Balto. Md.</u>	

Lucy Howard, Jr.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. [REDACTED]	
P-000 71 4236				71 4236	
BIRTH NO.				DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Robert L. Poe</u>				2. DATE AND HOUR OF DEATH <u>4-30-71</u> <u>3:50</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 Bolton Hill Nursing Home</u>				A. STATE <u>MARYLAND</u> B. COUNTY <u>Wiltshire</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2679 Wilkens Avenue</u> <u>21223</u>	
5. SEX <u>male</u>	6. RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/18/08</u>	9. AGE (In years last birthday) <u>63</u> 68	10. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction Worker</u>			11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Elizabeth Poe</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>225-03-5995</u>		17. INFORMANT <u>Mrs. Nell F. Poe, 2679 Wilkens Ave. 21223</u> <u>Admission Record</u>
18. <u>162.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CA / lung with relations</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/19</u> 19 <u>71</u> to <u>4/30</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>4/30</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>5/1/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>ALAN H. MONTAG</u>				23D. ADDRESS <u>2 E Pearl St Baltimore 21202</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>5-3-1971</u>		<u>Restwood Memorial Cemetery</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
<u>MAY 3 1971</u>		<u>Robert E. Taylor, M.D.</u>		<u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>	

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FUNERAL DIRECTOR: IMPORTANT

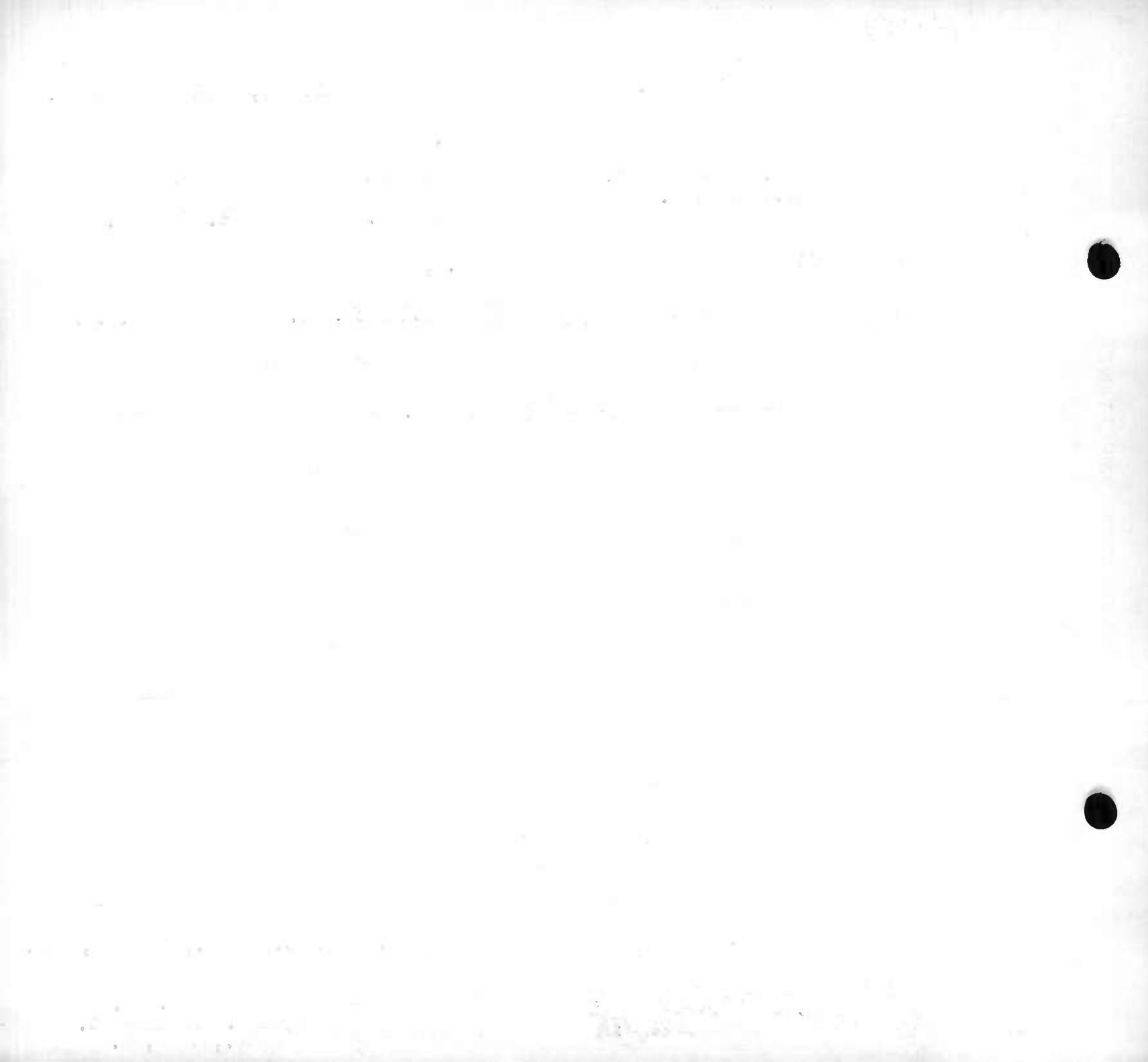
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 4237</u>
BIRTH NO. <u>W-425 71 4237</u>		1. NAME OF DECEASED (Type or Print) <u>Cora Willison</u>		
2. DATE AND HOUR OF DEATH <u>April 30, 1971</u> <u>5³⁰</u> P. M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00 222 East Barney Street</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2404</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>222 E. Barney Street</u>		
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 10, 1882</u>	9. AGE (in years last birthday) <u>89</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mender</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Linen Thread</u>		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Alec Emrick</u>		14. MOTHER'S MAIDEN NAME <u>Jane (Kennel)</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-24-6123</u>		17. INFORMANT ADDRESS <u>Mrs. K. Bierman - same as # 4</u>
18. <u>412.31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Arterio sclerotic Heart disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Generalized Arterio sclerotic</u>		
(B) DUE TO, OR AS A CONSEQUENCE OF: <u>?</u>		(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>4/25</u> 19 <u>70</u> to <u>4/30</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>4/30</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Dr. Harry Deibel</u>				23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) <u>DR. HARRY DEIBEL</u>		23D. ADDRESS <u>1726 Hanover St Balto 21230</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>May 4, '71</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Cumberland, Allegany Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 3 1971</u>		25B. NAME OF REGISTRAR <u>John E. Fisher</u>		25C. FUNERAL DIRECTOR ADDRESS <u>McCully-130 E. Fort Ave. Balto. Md. 21230</u>

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 4238</u>	
BIRTH NO. <u>A-240</u>		71 4238		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>THOMAS S. ASHLEY</u>			2. DATE AND HOUR OF DEATH <u>April 27, 1971</u> <u>9:00 P. M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00 2424 E. Baltimore St. Balto., 21224, Md.</u>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>602</u>		
5. SEX <u>Male</u>			6. RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>House Painter</u>		8. DATE OF BIRTH <u>Oct. 3, 1886</u>
13. FATHER'S NAME <u>Thomas Ashley</u>			14. MOTHER'S MAIDEN NAME <u>Anna Adams</u>		9. AGE (In years last birthday) <u>84</u> If Under 1 Yr. Months: Ours: If Under 24 Hrs. Hours: Min.
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>212-16-2199</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>
17. INFORMANT <u>Clara M. Ashley</u>			ADDRESS <u>Same</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute M.I.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCUND</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Carcinoma of Urinary Bladder</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE OLD INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>R. L. Doyle</u>				23B. DATE SIGNED <u>4-29-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>ROBERT L. DOYLE</u>				23D. ADDRESS <u>222 St. Paul St., Balto., 212, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-30-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Meadowridge Memorial</u>	
24D. LOCATION <u>Elkridge, Howard Co., Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 3 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Charles S. Jailer</u>			
25D. ADDRESS <u>901 S. Conkling St. Balto., 21224, Md.</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>71 4239</u>	
5-432 BIRTH NO.		71 4239					
1. NAME OF DECEASED (Type or Print) SCHULTZ, FRANK				2. DATE AND HOUR OF DEATH APRIL 30, 1971 2:05 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY 2534			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3720 FIFTH STREET 21225			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/08/11	9. AGE (In years last birthday) 59	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk-Stenographer			10B. KIND OF BUSINESS OR INDUSTRY Gen. Motors		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ANTON SCHULTZ				14. MOTHER'S MAIDEN NAME FRANCES KALIVODA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. 215-05-7717		17. INFORMANT CAITON AVES., BALTO., MD. 21229 ST AGNES HOSPITAL RECORDS-WILKENS AND			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Cardiac Arrhythmia with nodal bradycardia				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Cardiovascular Disease			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: Chronic Obstructive Pulmonary Disease			
				(C) Acute Renal Failure Acute Liver Failure			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from APRIL 27, 19 71 to APRIL 30, 19 71 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on APRIL 30, 19 71 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.							
23A. SIGNATURE Joseph H. Miller, M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED April 30, 1971	
23C. PHYSICIAN'S NAME (Type) JOSEPH H. MILLER				23D. ADDRESS 900 S. CATON AVE BALTO. 21229 MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-4-71		24C. NAME of CEMETERY or CREMATORY Glen Haven Cemetery		24D. LOCATION (City, town, or county) (State) Glen Burnie, AA MD.	
25A. DATE REC'D BY HEALTH DEPT. MAY 3 1971				25B. DATE OF REGISTRATION May 3, 1971			
				25C. FUNERAL DIRECTOR Mc Cully 237 Patapsco Ave. Balto. Md. 21225			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 4240</u>
BIRTH NO. <u>P-460</u>		71 4240		
1. NAME OF DECEASED (Type or Print) <u>Piller, Margaret A.</u>		2. DATE AND HOUR OF DEATH <u>April 28 1971 8:55 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 University Hospital</u>		A. STATE <u>Maryland</u> B. COUNTY <u>1903</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>308 S. Gilmore St</u>		
5. SEX <u>Female</u>	6. RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/23/84</u>	9. AGE (In years last birthday) <u>86</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Michael Doyle</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Hanley</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. John V. Piller, 1523 Langford Road, 21207</u>
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Probable Myocardial Infarction</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCD</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>April 23 1971</u> to <u>April 28 1971</u> that (I) <u>(we)</u> last saw the deceased alive on <u>April 28 1971</u> and that in (my), (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>(we)</u> <u>(did)</u> view the body after death.				
23A. SIGNATURE <u>Lawrence Piller, JMD</u>				23B. DATE SIGNED <u>4/28/71</u>
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-1-1971</u>		24C. NAME of CEMETERY or CREMATORY <u>New Cathedral Cemetery</u>
24D. LOCATION <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 3 1971</u>		
25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X CERTIFICATE OF DEATH		REG. NO. 71 4241	
7-625 71 4241 BIRTH NO.							
1. NAME OF DECEASED (Type or Print) FRESON, GEORGE JOSEPH, SR.				2. DATE AND HOUR OF DEATH APRIL 28, 1971		2:15A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		MARYLAND BALTIMORE 21227			
				C. CITY OR TOWN HALETHORPE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 5726 FIRST AVE.		5300	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 04 20 24	9. AGE (In years last birthday) 47	10. Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ROAD DRIVER			10B. KIND OF BUSINESS OR INDUSTRY TRANSFER & STORAGE		11. BIRTHPLACE (State or foreign country) WISCONSIN		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOSEPH FRESON				14. MOTHER'S MAIDEN NAME LOUISE (SEIFERT) SEIFERT			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW2		16. SOCIAL SECURITY NO. 391-20-0430		17. INFORMANT WILKENS AVES. BALTO. MD. 21229 ST. AGNES HOSPITAL RECORDS & CATON &			
18. 470.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE MYOCARDIAL INFARCTION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 1 (Month) 1 (Day) 1 (Year) 1 (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from APRIL 24 19 71 to APRIL 28 19 71 that (X) (we) last saw the deceased alive on APRIL 28 19 71 and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.							
23A. SIGNATURE Ching-Hui Tsai, M.D.				23B. DATE SIGNED 4/28/71			
23C. PHYSICIAN'S NAME (Type) Ching-Hui Tsai, M.D.				23D. ADDRESS ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTO., MD. 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-1-1971		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 3 1971		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave. 21229	

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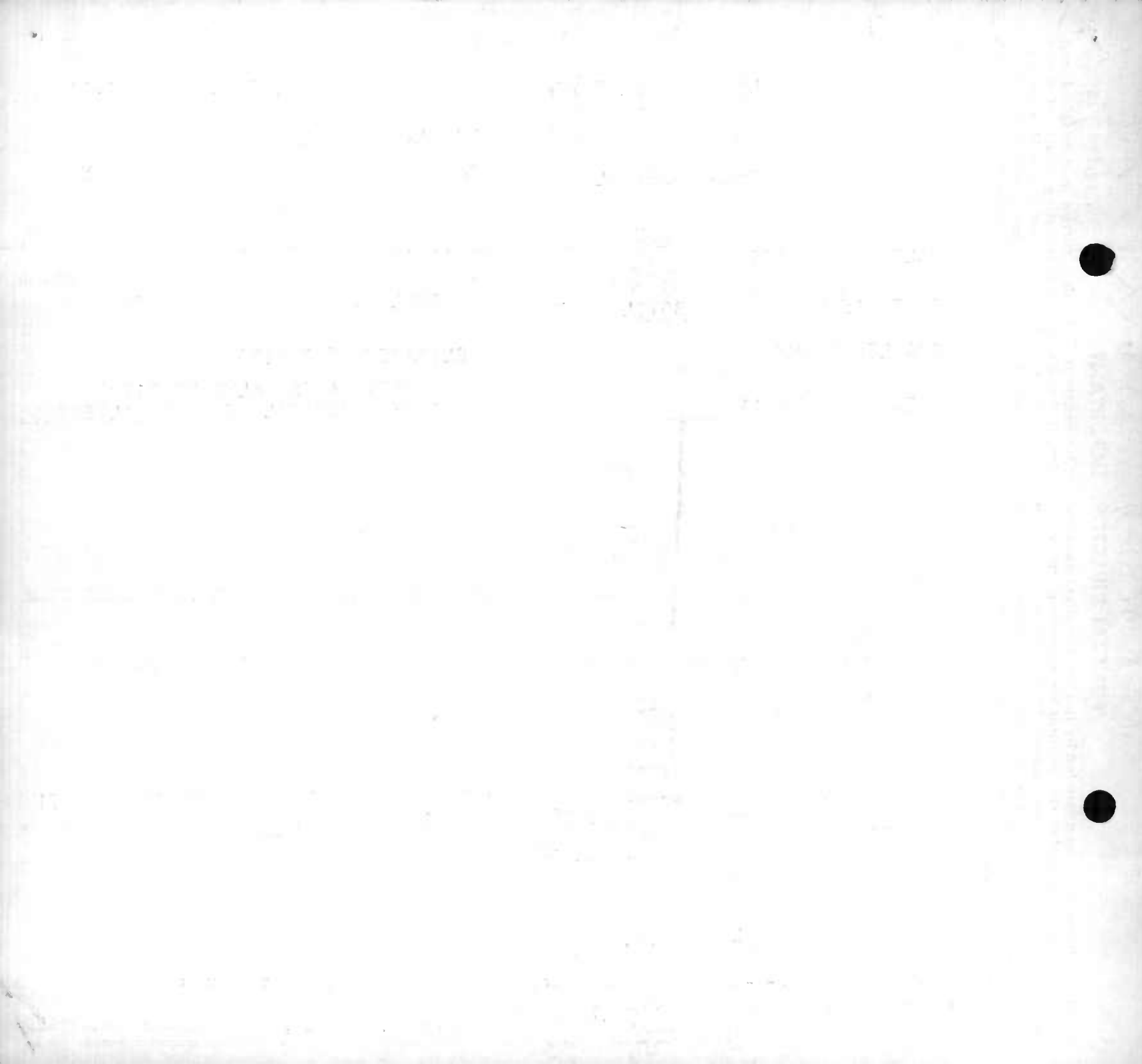
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NOT A MEDICAL EXAMINER'S CASE
W.U. Sp. 12
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

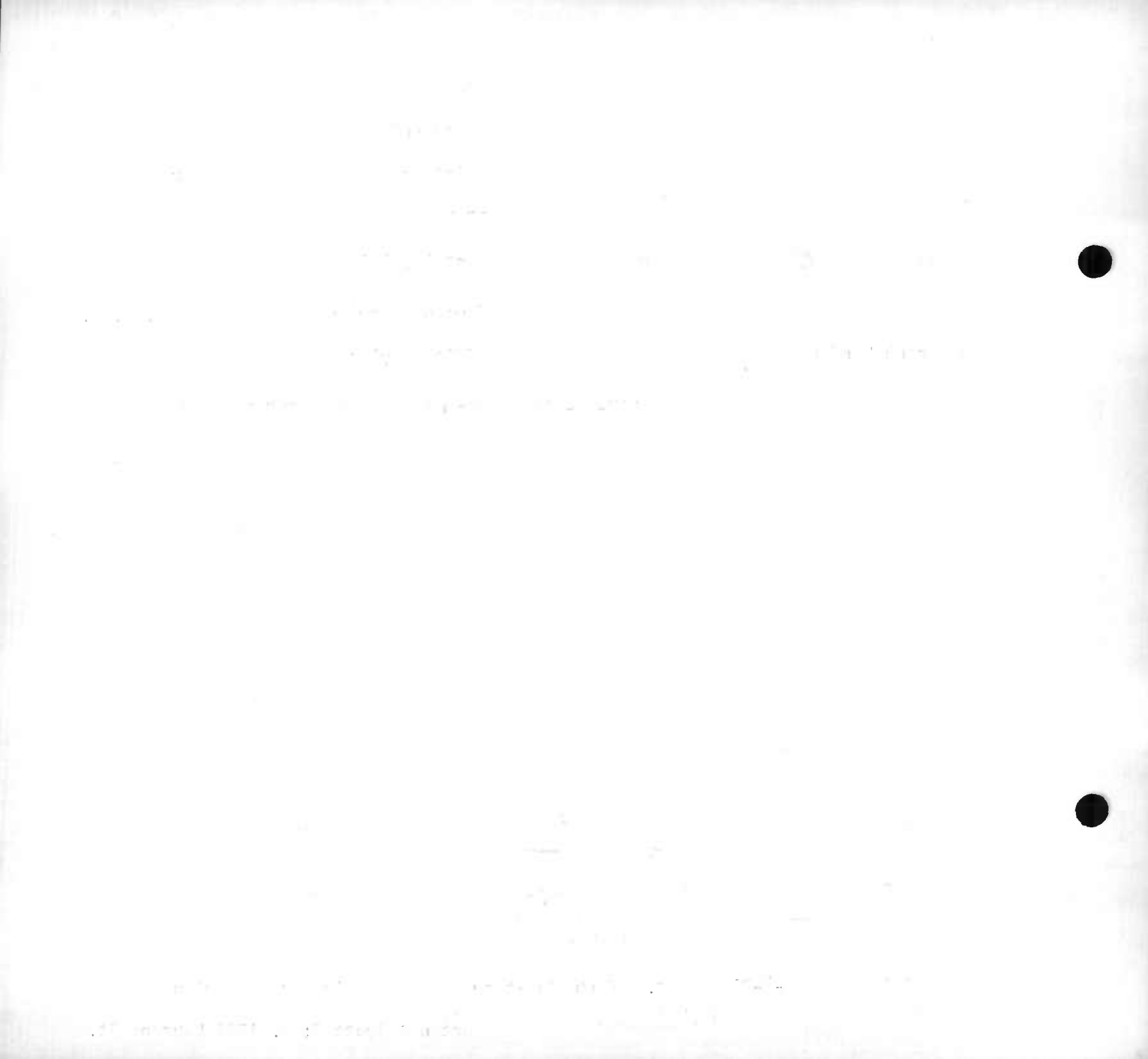
BIRTH NO. K-650				BALTIMORE CITY HEALTH DEPARTMENT			
71 4242				CERTIFICATE OF DEATH X REG. NO. 71 4242			
1. NAME OF DECEASED (Type or Print) KRUMM, LEONARD FORRESTER				2. DATE AND HOUR OF DEATH APRIL 28, 1971 1:31 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTO C. CITY OR TOWN Lansdowne D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 6 FOURTH AVENUE			
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 03 11 16	
9. AGE (In years last birthday) 55		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SUPERVISOR		10B. KIND OF BUSINESS OR INDUSTRY COCA COLA BOTTLING CO		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME CHARLES KRUMM				14. MOTHER'S MAIDEN NAME ELIZABETH (NORRIS)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW 11				16. SOCIAL SECURITY NO. 5-69,91			
17. INFORMANT CATON AVES BALTO MD 21229 ST AGNES HOSPITAL RECORDS WILKENS &				ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) HYPOVOLEMIC SHOCK & INFARCTED BOWEL & RENAL SHUT DOWN				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. MASSIVE UGI HEMORRHAGE				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 04 28 1971 to 04 28 1971 that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 04 28 1971 and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. (<input checked="" type="checkbox"/> (We) (did) (<input checked="" type="checkbox"/> (view) the body after death.							
23A. SIGNATURE M. Cabiling				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) M CABILING M.D.				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-1-1971		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 3 1971				25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 4243</u>
1. NAME OF DECEASED (Type or Print) <u>George Landon</u>		2. DATE AND HOUR OF DEATH <u>4/30/71</u> <u>7:25</u> P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Maryland General Hosp.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2562</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2703 Round Road</u>		
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 18, 1914</u>	9. AGE (In years last birthday) <u>56</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Towson, Maryland</u>
13. FATHER'S NAME <u>Frank Landon</u>		14. MOTHER'S MAIDEN NAME <u>Edith Taylor</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-05-5145</u>		17. INFORMANT <u>Frances Moody</u> ADDRESS <u>2703 Round Road</u>
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardiac Arrest</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Resp. Failure.</u> <u>Pulm. Embolus.</u> <u>COAD (Emphysema)</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>45 min.</u> <u>4 hrs.</u>
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u>				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that the (this hospital) attended the deceased from <u>4/30</u> 19 <u>71</u> to <u>4/30</u> 19 <u>71</u> that we (we) last saw the deceased alive on <u>4/30</u> 19 <u>71</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. We (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Juan M. Pardo M.D.</u> DEGREE				23B. DATE SIGNED <u>4/30/71</u>
23C. PHYSICIAN'S NAME (Type) <u>Juan M. Pardo MD</u>		23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>5-4-71</u>	24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 3 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>	25C. FUNERAL DIRECTOR <u>Morton & Dyett F. H.</u> ADDRESS <u>1701 Laurens St.</u>	



1

71 4244

BALTIMORE CITY HEALTH DEPARTMENT

T-520

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 4244

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print) CHARLES TONGUE

2. DATE OF DEATH Known ☒ Month Day Year Hour
Estimated ☐ May 1, 1971 M.

3. DATE OF DEATH Pronounced Dead Month Day Year Hour
May 1, 1971 12:55 A M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
Bon Secours Hospital (DOA)

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE Maryland B. COUNTY 1604

6. SEX Male 7. RACE Negro 8. MARRIED ☐ NEVER MARRIED ☐
WIDOWED ☐ DIVORCED ☐

9. DATE OF BIRTH 1-14-90 10. AGE (In years lost birthday) 80 11. BIRTHPLACE (State or foreign country) West River, Md.

12. CITIZEN OF WHAT COUNTRY? U. S. A. 13. FATHER'S NAME Richard Tongue

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 148. KIND OF BUSINESS OR INDUSTRY 15. MOTHER'S MAIDEN NAME Ida Tongue

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 17. SOCIAL SECURITY NO. 215-10-0888 18. INFORMANT ADDRESS Thelma Hills 234 Robinson St Schenectady, N.Y.

19. 412.4 CAUSE OF DEATH Arteriosclerotic cardiovascular disease
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) No

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 22F. HOW DID INJURY OCCUR?

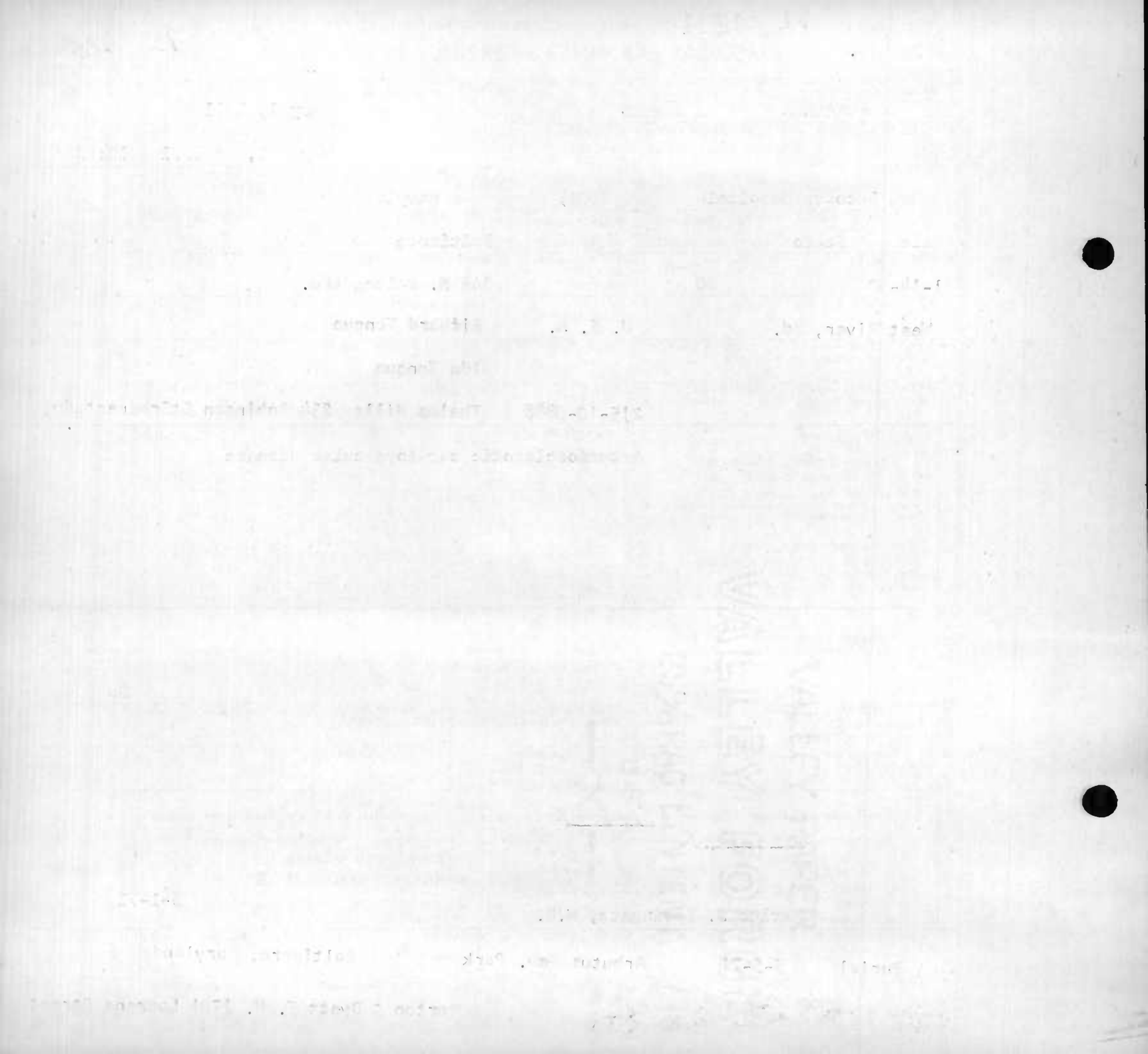
23. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE Charles S. Springate M.D. CHIEF MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER ☒ DATE SIGNED 5-1-71
ASSOCIATE MEDICAL EXAMINER ☐

24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 5-5-71 24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT. MAY 3 1971 25B. NAME OF REGISTRAR Robert E. Faber, Jr. 25C. FUNERAL DIRECTOR ADDRESS Morton & Dyett F. H. 1701 Laurens Street

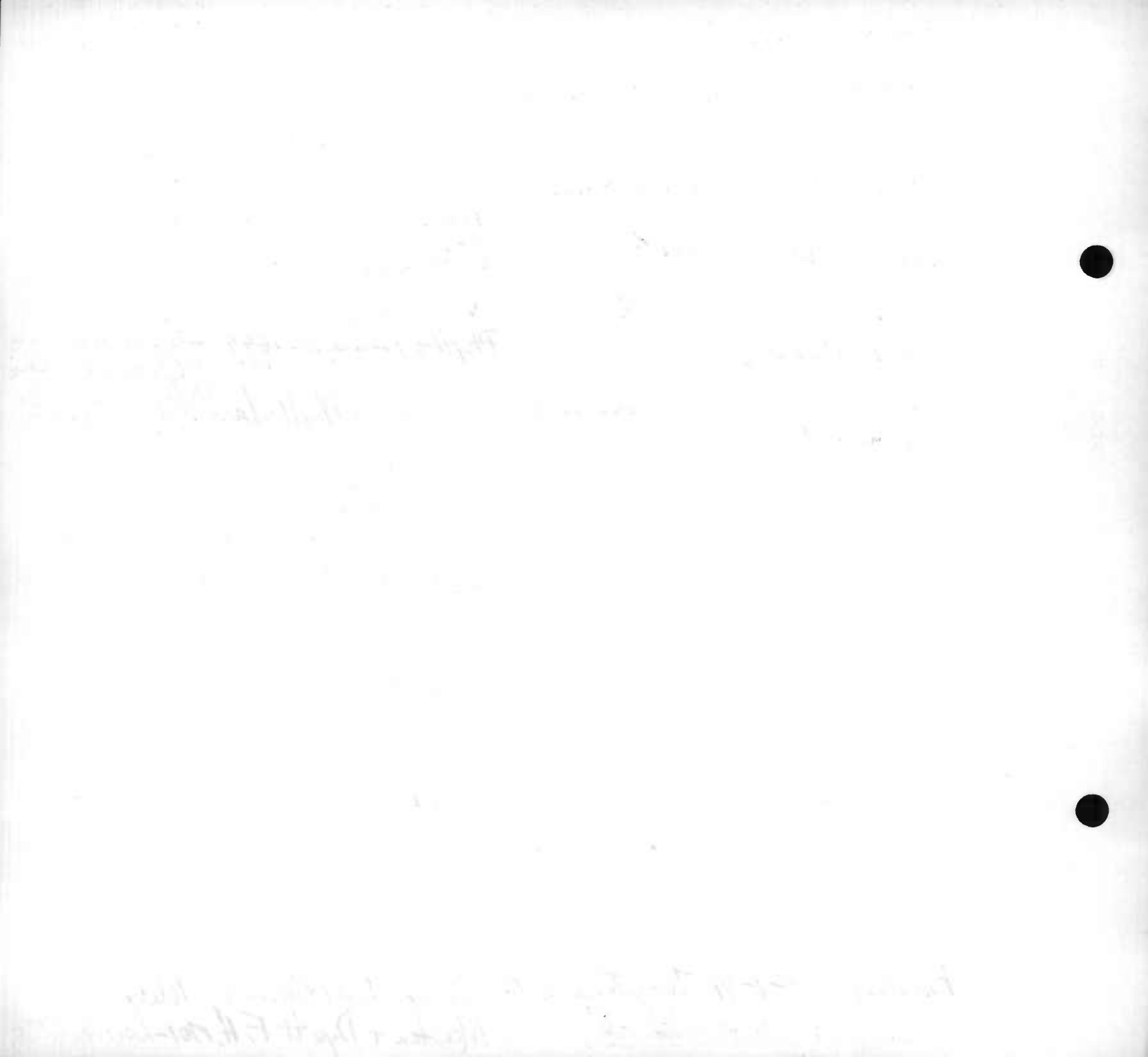
VS 151-REV. 1/1/68



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4245	
<div style="display: flex; justify-content: space-between;"> H-620 71 4245 71 4245 </div>					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) HARRIS, MR. JOHN B.			2. DATE AND HOUR OF DEATH 4/28/71 4:50 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY BALTO-CITY		
FULL NAME OF HOSPITAL OR INSTITUTION BON SECOURS HOSPITAL 34		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE B		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?		10B. KIND OF BUSINESS OR INDUSTRY ?		8. DATE OF BIRTH 06-07-08 9. AGE (In years last birthday) 62	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME SAUL HARRIS	
14. MOTHER'S MAIDEN NAME PHYLLIS LAGUER		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. 232-14-7539	
17. INFORMANT CHART Phyllis Lanker		18. CAUSE OF DEATH 4-25-X1		19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CONGESTIVE HEART FAILURE	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cardiomegaly Biventricular Hypertrophy + Dilatation Poss Idiopathic Cardiomyopathy		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH weeks months months	
23. MEDICAL CERTIFICATION 19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (A) (this hospital) attended the deceased from 4-28 19 71 to 4-28 19 71 that (B) (we) last saw the deceased alive on 4-28 19 71 and that in (C) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (D) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lidia L. de Borja M.D.			23B. DATE SIGNED 4-28-71		23C. PHYSICIAN'S NAME (Type) Lidia L. de Borja M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 5-1-71		24C. NAME OF CEMETERY OR CREMATORY Western Star Cem.
24D. LOCATION (City, town, or county) (State) Baltimore Md.			25A. DATE REC'D BY HEALTH DEPT. MAY 3 1971		
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.			25C. FUNERAL DIRECTOR Morton & Dyett F. H. 1701-Lawrence St.		



7-326

71 4246

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 4246

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN JAMES FITZGERALD				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> April 30, 1971		Hour 9:00 P.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital				3. DATE PRONOUNCED DEAD Month Day Year April 30, 1971		Hour 9:00 P.	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 833			
6. SEX Male		7. RACE Negro		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
10. AGE (In years last birthday) 4-5-64		11. AGE (In years last birthday) 7		E. STREET AND NUMBER 2410 E. Biddle		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland				12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Franklin James	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				15. MOTHER'S MAIDEN NAME Margaret Williams			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				17. SOCIAL SECURITY NO.		18. INFORMANT Mr. Franklin James	
19. CAUSE OF DEATH E 916 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		21. AUTOPSY? (Yes or No) No	
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Loading area		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Supermarket, 2305 Chase St. 504	
22D. TIME OF INJURY (APPROX.) 4-30-71 7:45 P.				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? 400 pound cart fell on head while victim was playing with children	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 5-1-71							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-4-71		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 3 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS Morton & Dyett F. H. 1701 Laurens Street			

WALL & CO. PRODUCE

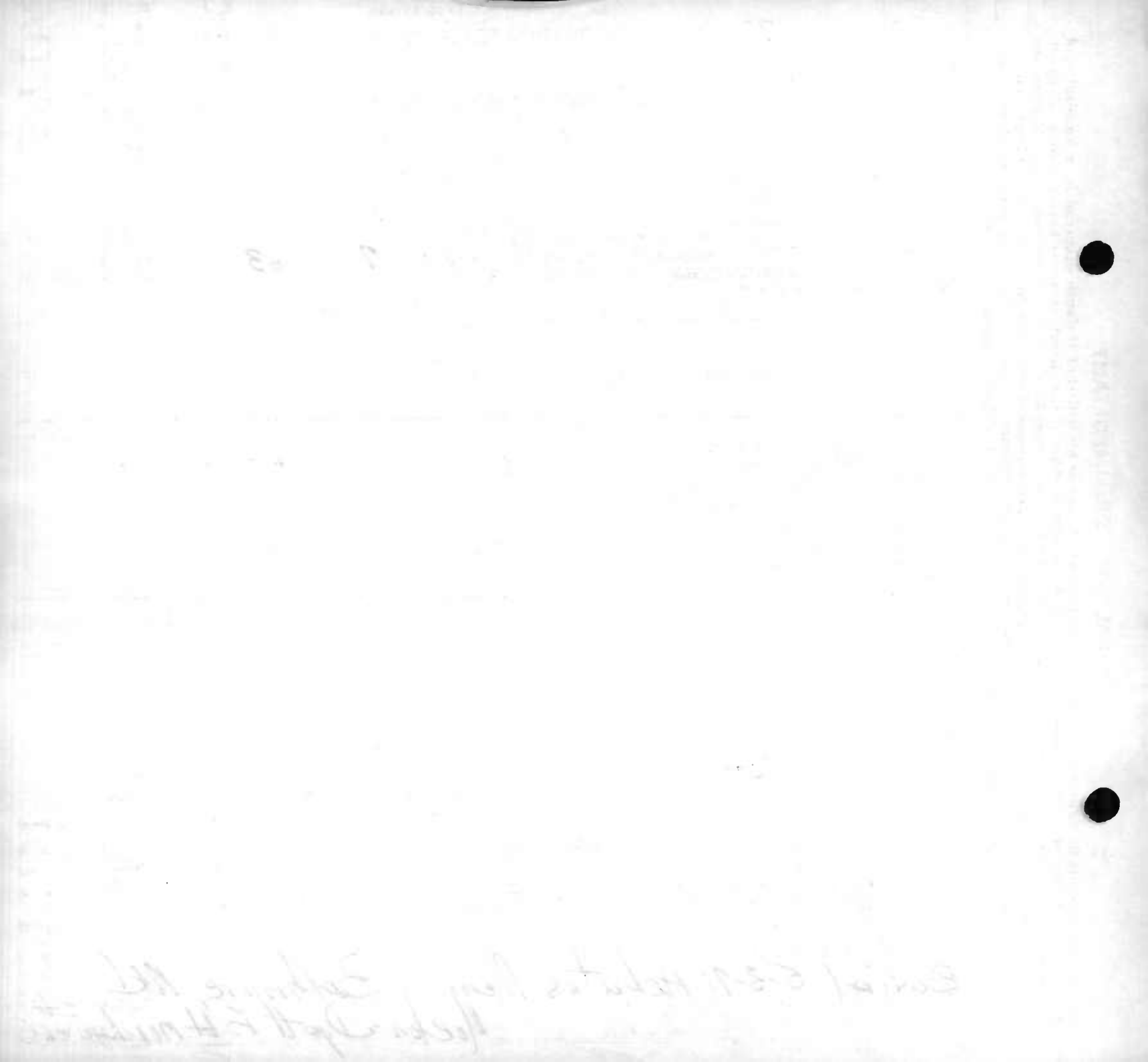
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WALL & CO. PRODUCE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. <u>7-512</u> <u>71</u> <u>4247</u>					REG. NO. <u>71</u> <u>4247</u>				
1. NAME OF DECEASED (Type or Print) <u>Erolia Thompson</u>					2. DATE AND HOUR OF DEATH <u>4-30-71</u> <u>9:30 A.M.</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1301</u>				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>43 South Balt. Gen. Hosp.</u>					C. CITY OR TOWN <u>Balt.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
					E. STREET AND NUMBER <u>727 Oriol Park Lake Dr.</u>				
5. SEX <u>Female</u>	6. RACE <u>166 N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-28-07</u>	9. AGE (In years last birthday) <u>63</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Neal Clark</u>					14. MOTHER'S MAIDEN NAME <u>Elizabeth Pearson</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
18. <u>183.01</u> CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Metastatic ovarian carcinoma</u>					<u>6 wks.</u>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				
					(B) DUE TO, OR AS A CONSEQUENCE OF:				
					(C) DUE TO, OR AS A CONSEQUENCE OF:				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If only medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>3-29</u> 19 <u>71</u> to <u>4-30</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>4-30</u> 19 <u>71</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Daniel M. Howell M.D.</u>					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4-30-71</u>		
23C. PHYSICIAN'S NAME (Type) <u>D m Howell M.D.</u>					23D. ADDRESS				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-3-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 3 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, R.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Robert E. Fisher, R.D.</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 4248</u>	
BIRTH NO. <u>71 4248</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>ELLA M BEDFORD</u>			2. DATE AND HOUR OF DEATH <u>April 29, 1971</u> <u>8:00 P.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>833</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u> <u>2615 Llewellyn Avenue</u> <u>Baltimore, Maryland 21213</u>			C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER <u>2615 Llewellyn Avenue</u>		
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-21-09</u>	9. AGE (In years last birthday) <u>61</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Union, South Carolina</u>	
13. FATHER'S NAME <u>Tom Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Ella Rochelle</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Fannie Roles 2004 E. Lanvale St. 21213</u>	
18. <u>71019 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <u>Acute myocardial infarction</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1965</u> to <u>April 29, 1971</u> , that (I) (was) lost saw the deceased alive on <u>Feb 11</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we did) (did not) view the body after death.					
23A. SIGNATURE <u>Seymour H. Rubin</u> DEGREE				23B. DATE SIGNED <u>4/30/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Seymour H. Rubin, M.D.</u> DEGREE				23D. ADDRESS <u>5415 Park Heights Avenue 21215</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-3-1971</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		(City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 4 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fubly, Jr.</u>		25C. FUNERAL DIRECTOR <u>Marshall W. Jones, Jr. 1735 Harford Ave.</u>	

Pointe au Lac
Quebec

St. John's
Nfld.

St. John's
Nfld.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

71 4249

BIRTH NO.

71 4249

1. NAME OF DECEASED
(Type or Print)

Susie C. Jenkins Lumpkin

2. DATE AND HOUR OF DEATH

4/29/71

11:30 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

The Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

E. STREET AND NUMBER

1831 N. Spring Street

5. SEX

Female

6. RACE

Negro

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

10/2/92

9. AGE (In years
last birthday)

78

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Wilfred C. Jenkins

14. MOTHER'S MAIDEN NAME

Sarah Jenkins

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

212-07-7970B

17. INFORMANT

ADDRESS

Mrs. Mildred Pack 1831 N. Spring St. 21213

18. DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Uremia

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

2 weeks

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Pyelonephritis

years

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A)

Anoxia 2° to disconnection of respirator tubing 5 days

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

No

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/19 1971 to 4/29 1971
that (I) (we) last saw the deceased alive on 4/29 1971 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

James C. Bobrow, M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

4/30/71

23C. PHYSICIAN'S
NAME (Type)

James C. Bobrow M.D.

23D. ADDRESS

The Johns Hopkins Hospital

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

5-4-71

24C. NAME OF CEMETERY OR CREMATORY

Baltimore National Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

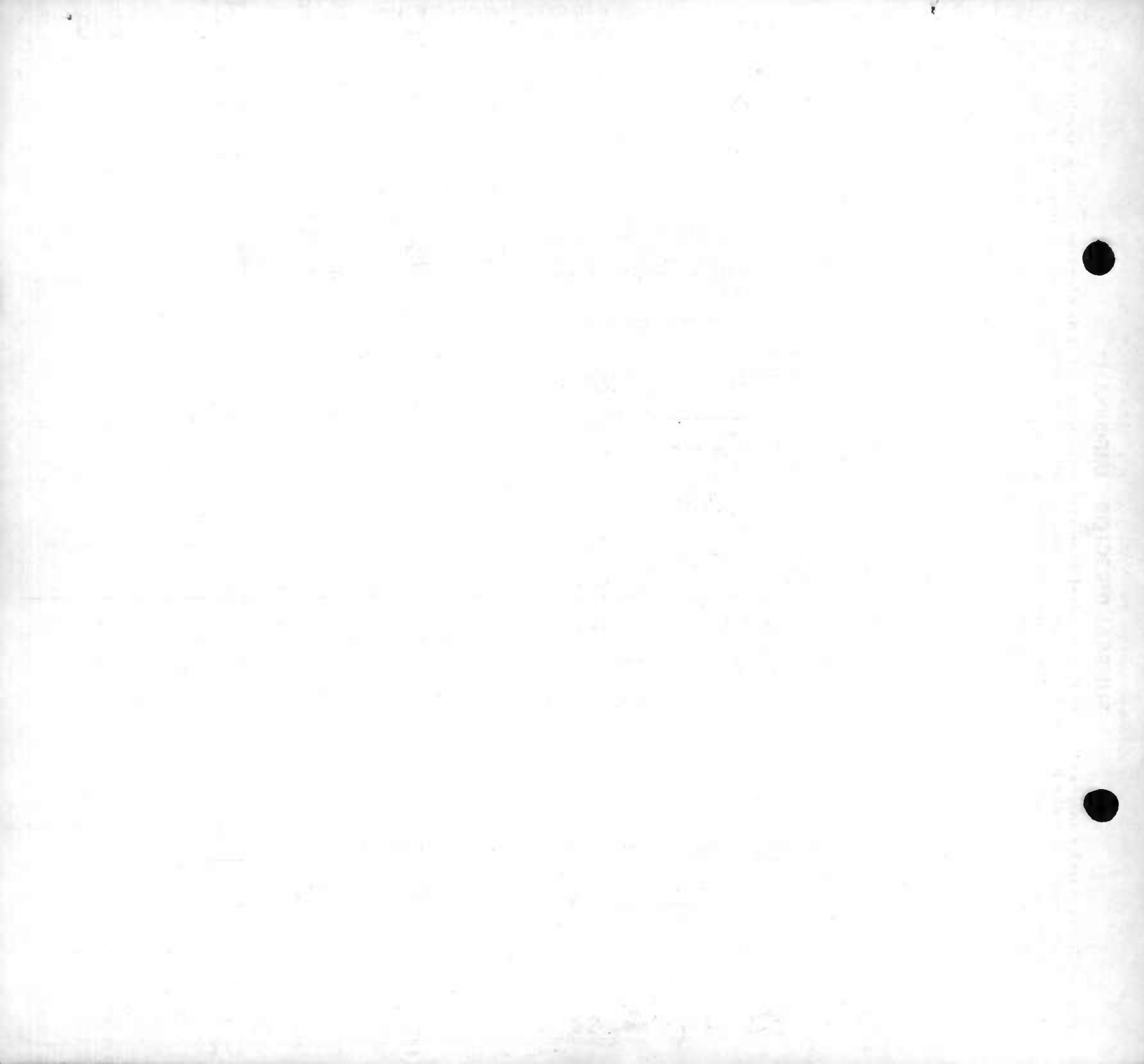
25A. DATE RECD BY HEALTH DEPT.

MAY 4 1971 Robert E. Taylor, R.D.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR 1735 Harford Ave. 21213
Marshall W. Jones, Jr.

ADDRESS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-4001

71 4250

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 71 4250

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

RACHEL Neely

2. DATE AND HOUR OF DEATH

4-29-71

5:45 PM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

BOLTON HILL NURSING HOME

90

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

MARYLAND

2003

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

100 S. MONROE STREET

5. SEX

Female

6. RACE

Negro

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

4/17/89

9. AGE (in years last birthday)

82 yrs

If Under 1 Yr. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Alex Gray

14. MOTHER'S MAIDEN NAME

Alice Gray

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Admission Record

ADDRESS

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Central Pulmonary embolism

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

3/28/71

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO, OR AS A CONSEQUENCE OF:

Hypertensive C.V. disease

2 yrs

(C) DUE TO, OR AS A CONSEQUENCE OF:

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 4/9 1971 to 4/29 1971 that (I) (we) last saw the deceased alive on 4/29 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

[Signature]

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

4/30/71

23C. PHYSICIAN'S NAME (Type)

Dr. H. H. M. DENT M.D.

23D. ADDRESS

2500 E. Pratt St. Baltimore, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

Transfer-Burial 5/4/71

Piney Grove

Salisbury, North Carolina

25A. DATE REC'D BY HEALTH DEPT.

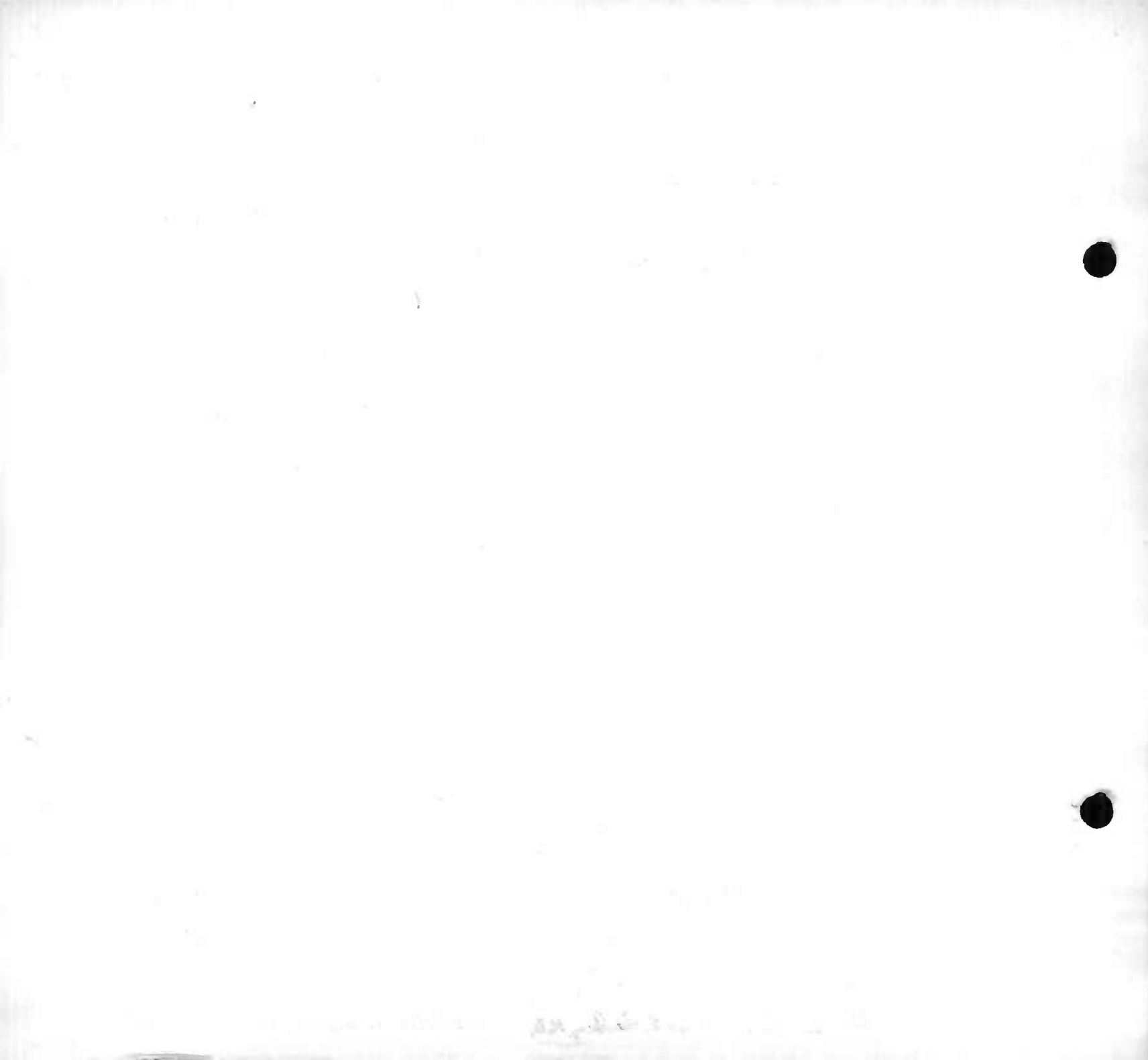
MAY 4 1971

25B. NAME OF REGISTRAR

John E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Marshall W. Jones, Jr. 1735 Harford Ave



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 71 4251				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 4251	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) Anna R. Kettler				2. DATE AND HOUR OF DEATH May 3, 1971			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 General German Aged Home 22 S. Athol Avenue				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2864 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 22 S. Athol Avenue, Baltimore, Md.			
5. SEX Fem.	6. RACE Caucasion	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 14, 1890	9. AGE (In years last birthday) 81	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto, Md		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME George A. Neubauer			14. MOTHER'S MAIDEN NAME Catherine				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 212-20-0573		17. INFORMANT General German Aged Home, 22 S. Athol Ave.		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE Poor Nutrition DUE TO, OR AS A CONSEQUENCE OF: (B) Generalized Arterio sclerosis DUE TO, OR AS A CONSEQUENCE OF: (C) Senility		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Mar 19 70 to 3 May 19 71 that (I) (we) last saw the deceased alive on 3 May 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE William J. Bryson				23B. DATE SIGNED 3 May 71			
23C. PHYSICIAN'S NAME (Type) Dr. William J. Bryson				23D. ADDRESS 4605 Edmondson Avenue, Baltimore, Md. 21229			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 5/5/71		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 4 1971		25B. NAME OF REGISTRAR J. E. Taylor, Jr.		25C. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave., 21229		ADDRESS	

adm. 5/4/62

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 71 4252

BIRTH NO. 71 4252

1. NAME OF DECEASED
(Type or Print)

Elizabeth W. Bobart

2. DATE AND HOUR OF DEATH

May 1, 1971

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

90 General German Aged Home
22 S. Athol Avenue

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

E. STREET AND NUMBER

22 South Athol Avenue,

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

5. SEX

Female

6. RACE

Caucasian

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH

Sept 28, 1880

9. AGE (In years last birthday)

90

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Wales

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Late Richard D. Williams

14. MOTHER'S MAIDEN NAME

late Mary Michael

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

General German Aged Home, 22 S. Athol Ave.

18. 440.91

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

Dehydration + Malnutrition

(B) Antecedent Cause DUE TO, OR AS A CONSEQUENCE OF:

Advanced senescent arteriosclerosis

(C) Sensitivity

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 1968 to May 1 1971 that (I) (we) last saw the deceased alive on 1 May 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S NAME (Type)

William J. Bryson, MD

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

3 May 71

23D. ADDRESS

4605 Edmondson Avenue, Baltimore, Md.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

5/4/71

24C. NAME OF CEMETERY or CREMATORY

The Chestnut Grove Cemetery

24D. LOCATION

Sweet Air, Maryland

25A. DATE REC'D BY HEALTH DEPT.

MAY 4 1971

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Witzke, 4101 Edmondson Av., Balto., Md. 21229

ADDRESS

69/11/4 14-0533

VI 4525

20

20 58,1880

A2U

Wales

Housewife

Late Mary Michael

Late Richard D. Williams

General German Aged Home, 22 S. Athol Ave.

*Revised Cemetery records
Baltimore
Population 1940*

17 to May 17

June 17

May 17

3 May 17

4605 Edmondson Avenue, Baltimore, Md.

William J. Bryson, Md

The Chestnut Grove Cemetery Sweet Air, Maryland

5/4/71

Burial

4605 Edmondson Ave Baltimore, Md 21206

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 4253

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ELBERT LENKER

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

May 1, 1971

3:15 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
HOSPITAL ADDRESS OR LOCATION)
OR INSTITUTION

40 St. Agnes Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

May 1, 1971

3:15 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

5300

6. SEX

Male

7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐ NO ☒

9. DATE OF BIRTH

Aug. 6, 1923

10. AGE (In years
lost birth day)

47

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER 603 Southmont Rd., 21228

603 Southmont Street

11. BIRTHPLACE (State or foreign country)

Elmont, Virginia

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Karl Lenker (late)

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Engineer

14B. KIND OF BUSINESS OR INDUSTRY

Westinghouse

15. MOTHER'S MAIDEN NAME

Eleanora Siebe (late)

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WW II

17. SOCIAL
SECURITY NO.

224-16-2736

18. INFORMANT

Mrs. Elbert H. Lenker, 603 Southmont Rd., 21228

ADDRESS

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Multiple injuries
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)
Street22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Rt. #695 South of Wilkins Avenue

22D. TIME
OF INJURY
(APPROX.)(Month) (Day) (Year) (Hour)
5-1-71 11:03 A. m.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subject picking up wood fallen from
vehicle, when struck by another auto

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐
and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

May 2, 1971

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

24C. NAME of CEMETERY or CREMATORY

Gettysburg Natl. Cemetery

24D. LOCATION (City, town, or county)

Gettysburg, Md.

25A. DATE REC'D BY HEALTH DEPT.

MAY 4 1971

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Witzke, 1630 Edmondson Av., Catonsville, Md.

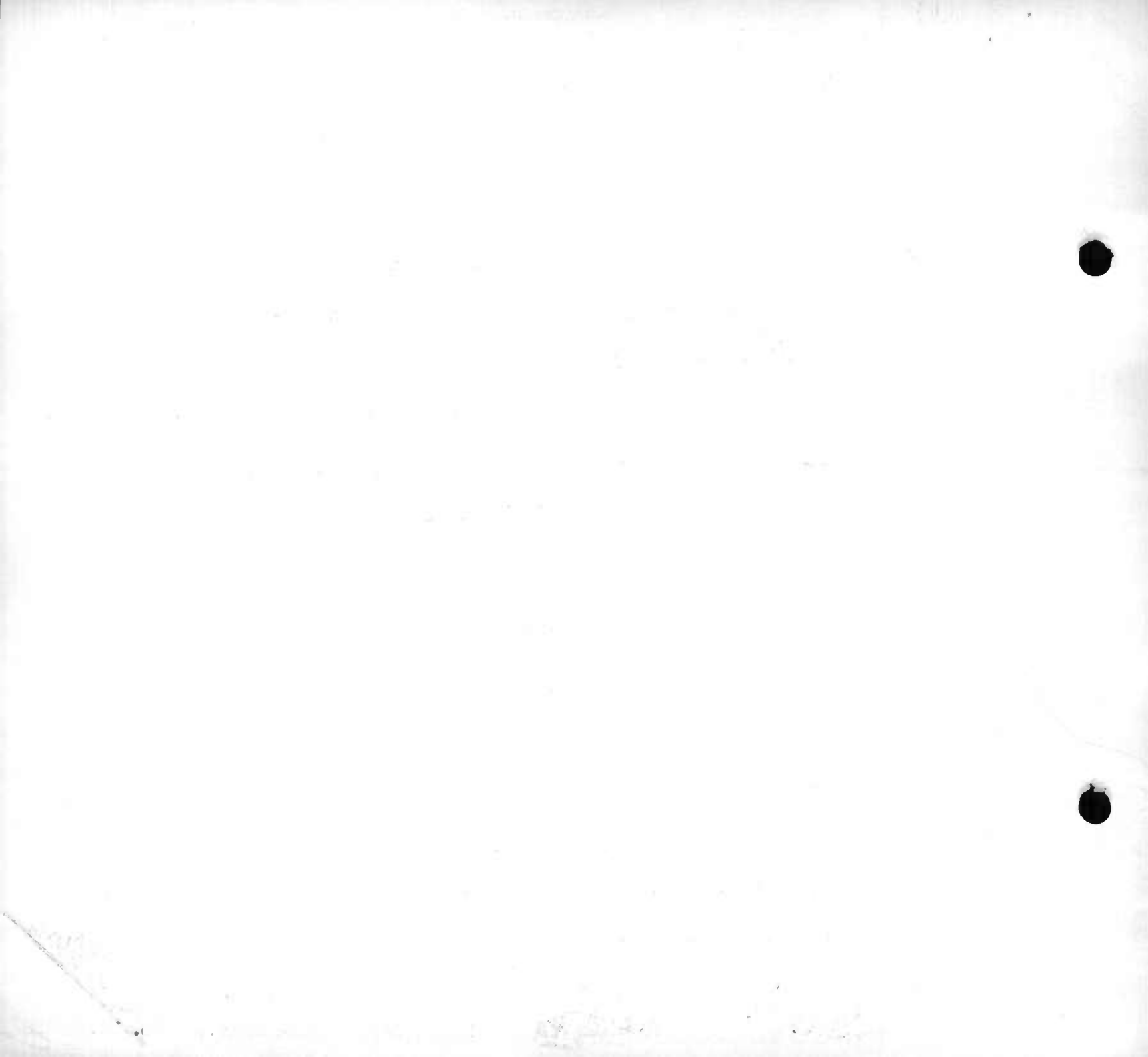
ADDRESS

21228

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. <u>71 4254</u>	
BIRTH NO. <u>71 4254</u>		CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <u>WILLIAM MONAGHAN</u>				2. DATE AND HOUR OF DEATH <u>5-2-71</u> <u>3:30 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>37 MERCY Hospl.</u>				A. STATE <u>MD.</u>		B. COUNTY <u>BALTO</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>BALTO</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <u>901 ST. AGNES LA.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-4-03</u>	9. AGE (In years last birthday) <u>68</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETD Supervisor</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Taxi Bureau</u>		11. BIRTHPLACE (State or foreign country) <u>Wilmington, Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HARRY MONAGHAN (late)</u>				14. MOTHER'S MAIDEN NAME <u>(late) Anna ?</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Mary G. Monaghan, 901 St. Agnes Lane,</u>	
						ADDRESS <u>21207</u>	
18. <u>4-3-91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u> (A) IMMEDIATE CAUSE <u>CEREBRAL INFARCTIONS</u> DUE TO, OR AS A CONSEQUENCE OF: <u>ARTERIOSCLEROSIS</u> (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>AZOTEMIA</u>							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>4-13-1971</u> to <u>5-2-1971</u> that (1) (we) last saw the deceased alive on <u>5-2-1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Aidan E. Walsh</u>				23B. DATE SIGNED <u>5-2-71</u>			
23C. PHYSICIAN'S NAME (Type) <u>AIDAN E. WALSH</u>				23D. ADDRESS <u>222 ST. PAUL, BALTO 2, MD</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>5/5/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Crestlawn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 4 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>Witzke, 1630 Edmondson Av., Balto., Md. 21228</u>			



EGH

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 25		71 4255		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 4255	
1. NAME OF DECEASED (Type or Print) GAEGLER, JOSEPH WILLIAM				2. DATE AND HOUR OF DEATH 05-02-71 1:51 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL WILKENS & CATON AVENUES BALTIMORE, MARYLAND 21229				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 1912 BEVERLY ROAD 21228			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-12-01	9. AGE (In years last birthday) 69	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) VICE PRESIDENT	11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME WILLIAM A. GAEGLER				14. MOTHER'S MAIDEN NAME CARRIE HACK			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 215076073			
17. INFORMANT Mrs. Frances V. Gaegler, 1912 Beverly Rd.				18. CAUSE OF DEATH ST AGNES HOSPITAL, WILKENS & CATON AVES			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial Infarction				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Atherosclerotic Cardio Vascular Disease							
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from APRIL 28, 1971 to MAY 2, 1971 and that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on MAY 2, 1971 and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.							
23A. SIGNATURE SALVADOR QUIROZ M.D.				23B. DATE SIGNED 05 02 71		23C. PHYSICIAN'S NAME (Type) SALVADOR QUIROZ M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE May 5, 1971		24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	
24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland - 21207				25A. DATE REC'D BY HEALTH DEPT. MAY 4 1971		25B. NAME OF REGISTRAR Witzke, 1630 Edmondson Av., Balto., Md. 21228	
25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Av., Balto., Md. 21228				25D. ADDRESS			

FUNERAL DIRECTOR: IMPORTANT

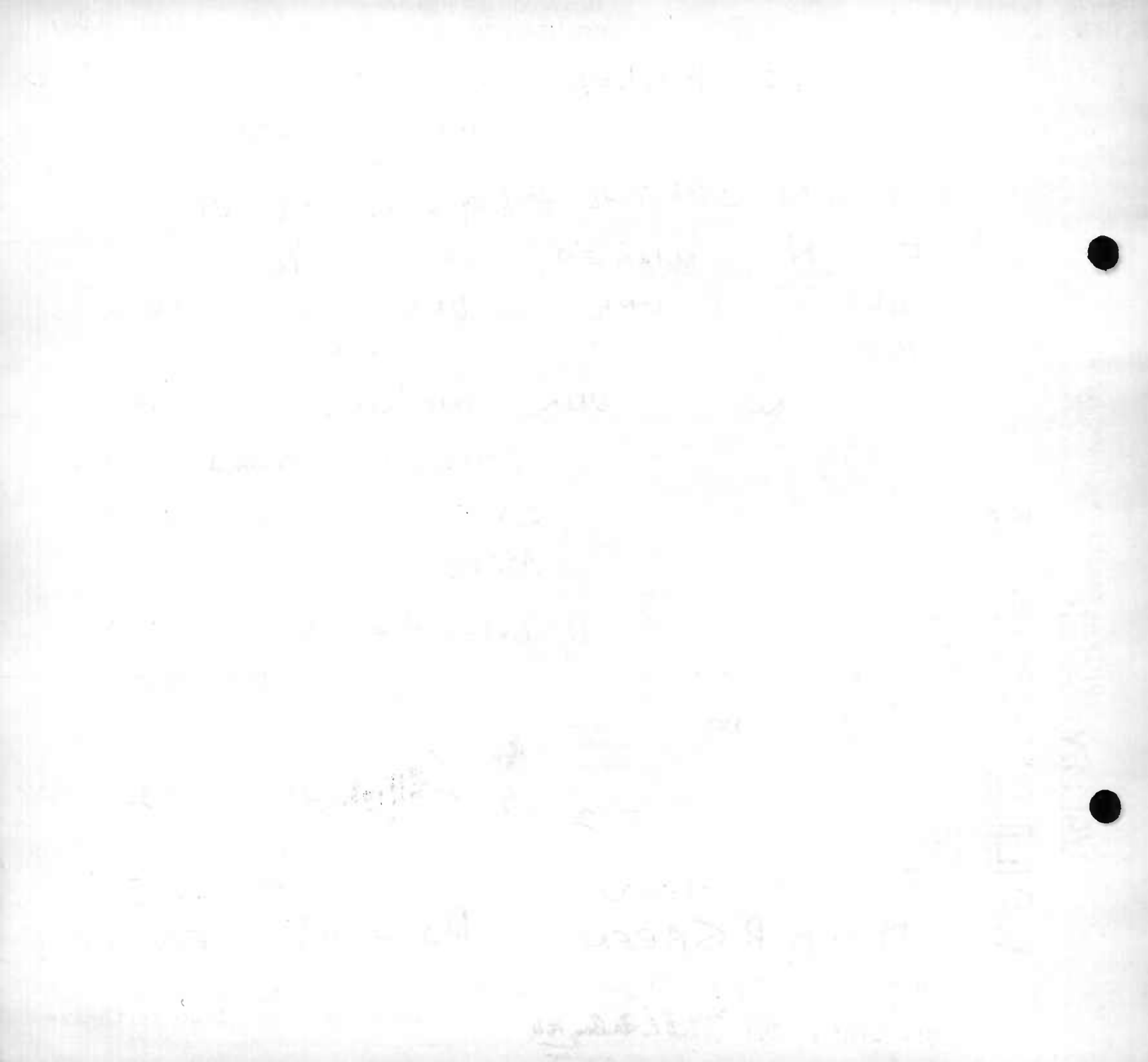
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 71 4256		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 4256	
1. NAME OF DECEASED (Type or Print) Mary E. Pinkney			2. DATE AND HOUR OF DEATH May 1, 1971		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 00 330 N. Stricker St.			A. STATE Md. B. COUNTY 1901		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 330 N. Stricker St.		
5. SEX Female	6. RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 5, 1906	9. AGE (In years last birthday) 64	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Annapolis Md.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Ned Clay			14. MOTHER'S MAIDEN NAME Elizabeth Green		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS James H. Pinkney 330 N. Stricker St.		
18. 1829 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) Terminal Cancer of uterus ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cadexia (B) Due to, or as a consequence of: Diabetes (C) Due to, or as a consequence of: Diabetes			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 4-26 19 71 to 5-1 19 71 , that (1) (we) last saw the deceased alive on 5-1 19 71 and that (1) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]			23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) N. K. Z. W. A.			23D. ADDRESS 521 W. Lexington St. 21201		
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/5/71		24C. NAME OF CEMETERY or CREMATORY W. Auburn Cem.	
24D. LOCATION Balto Md		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. MAY 4 1971		25B. NAME OF REGISTRAR R. E. J. Bay, Jr.		25C. FUNERAL DIRECTOR Williams Funeral Home 99 N. Schroeder	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

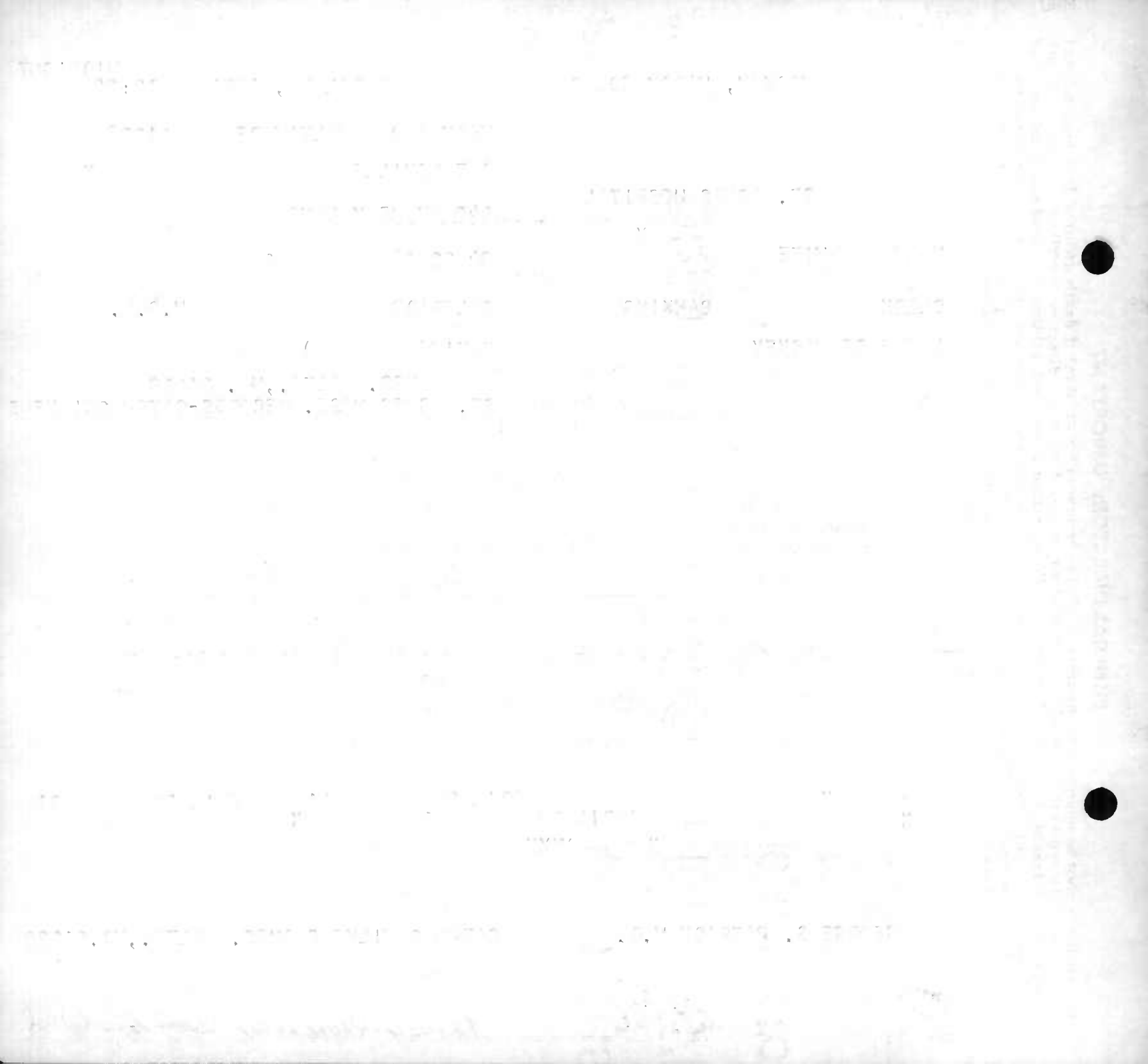
BIRTH NO. 71 4257				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 71 4257	
CERTIFICATE OF DEATH							
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) SUSIE WALKER				5.3.71 6 ¹⁰ P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
MARYLAND GENERAL HOSP				MD. BALTO		1602	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				BALTO			
				D. STREET ADDRESS (If rural, give location)			
				915 N. STRICKER ST			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours
F	N	MARRIED	UNK	76			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
UNK		UNK		UNK		U.S.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
UNK				UNK			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO		UNK		Husband		SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO		4 days	
ANTECEDENT CAUSES				(B) DUE TO		4 days	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) ASCVD		years	
II				Diabetes Mellitus		YEARS	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				YES		Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
NO							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 4/30 1971 to 5/3 1971, that (I) (we) last saw the deceased alive on 5/3/71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
David P. GREEN M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				5/3/71			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
DAVID P. GREEN M.D.				MARYLAND GEN. Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		5/4/71		New Cathedral Cemetery		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAY 4 1971		Robert E. Talbot, Jr.		Adolphus Halstead		1206 North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

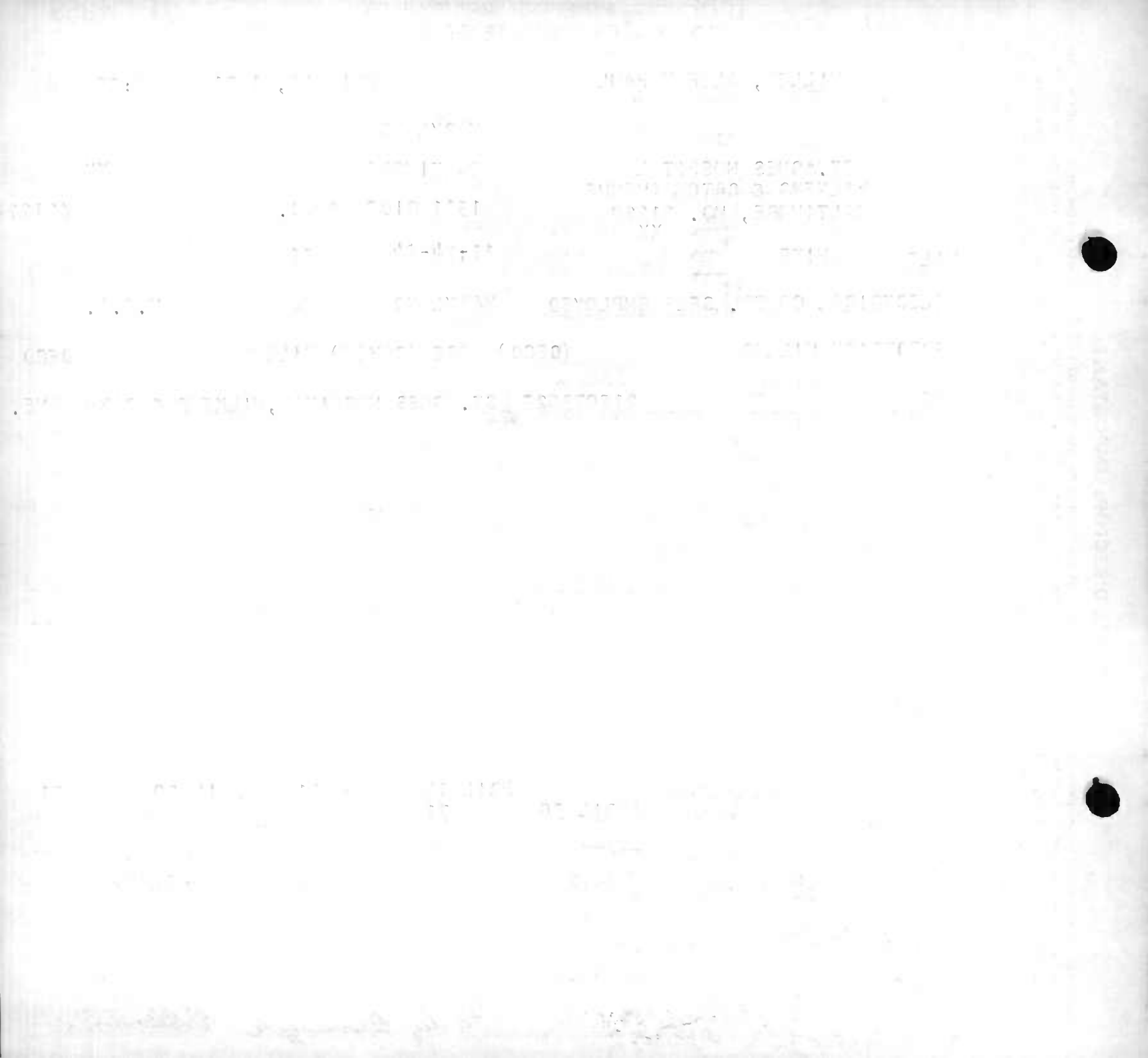
W-200		71 4258		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 71 4258	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH				MIDNIGHT	
WASKEY, HARRY EDWARD				APRIL 29, 1971				12:00 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL				A. STATE MARYLAND				B. COUNTY BALTIMORE	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN CATONSVILLE				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 140 NUNNERY LANE					
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 04 22 08	9. AGE (In years last birthday) 63	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERK			10B. KIND OF BUSINESS OR INDUSTRY BANKING			11. BIRTHPLACE (State or foreign country) COLORADO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LAWRENCE WASKEY				14. MOTHER'S MAIDEN NAME KATIE() WELSH					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 213-101118		17. INFORMANT AVES. BALTO., MD. 21229 ST. AGNES HOSP. RECORDS-CATON & WILKENS				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: hypoxia (B) DUE TO, OR AS A CONSEQUENCE OF: Atherosclerosis (C) DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction flail chest 2 to resuscitation APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (X) (this hospital) attended the deceased from APRIL 27 1971 to APRIL 29 1971 that (X) (we) last saw the deceased alive on APRIL 29 1971 and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.									
23A. SIGNATURE George S. Patrick M.D.				23B. DATE SIGNED 4/29/71				23C. PHYSICIAN'S NAME (Type) GEORGE S. PATRICK M.D.	
23D. ADDRESS CATON & WILKENS AVES. BALTO., MD. 21229									
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 5-3-71		24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md.			
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR TERRY KAUCHAUGH			25C. FUNERAL DIRECTOR TERRY KAUCHAUGH			
25D. ADDRESS									



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				CERTIFICATE OF DEATH		BIRTH NO. 71 4259	
1. NAME OF DECEASED (Type or Print) MILLER, ALBERT PAUL				2. DATE AND HOUR OF DEATH APRIL 30, 1971 8:35 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY 5300			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION WILKENS & CATON AVENUE		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 1311 RIDGE ROAD		F. ZIP CODE 21228		G. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		H. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-24-04	9. AGE (in years last birthday) 66	If Under 1 Yr. Months: Days: Hours: Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICAL CONTR. SELF EMPLOYED
11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME FREDERICK MILLER			14. MOTHER'S MAIDEN NAME (DECD) ROSE (CAVEY) MILLER				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 215073025		17. INFORMANT ST. AGNES HOSPITAL, WILKENS & CATON AVE.		ADDRESS DECD
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, aethenia, etc. It means the disease, injury or complication which caused death.) TERMINAL CA.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: GASTRIC CA. W/ WIDESPREAD METASTASIS				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			(B) DUE TO, OR AS A CONSEQUENCE OF: INOOPERABLE ABDOMINAL AORTIC ANEURYSM				
19A. DATE OF OPERATION 4/23/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED AORTIC ANEURYSM		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from APRIL 12 19 71 to APRIL 30 19 71 that (I) (we) last saw the deceased alive on APRIL 30 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE M. Rabiling MD				23B. DATE SIGNED 4/30/71		23C. PHYSICIAN'S NAME (Type) M. RABILING	
23D. ADDRESS ST. AGNES HOSP				23E. NAME OF REGISTRAR Farley		23F. FUNERAL DIRECTOR Edwards	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 5-3-71		24C. NAME OF CEMETERY OR CREMATORY Catholic Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
24E. STATE RECORDING HEALTH DEPT. MAY 4 1971				24F. NAME OF REGISTRAR Farley			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 71 4260				BALTIMORE CITY HEALTH DEPARTMENT		71 4260	
CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print) FREDERICK N. LIEBAU				2. DATE AND HOUR OF DEATH 4/30/71 9:20 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MARYLAND General Hosp				A. STATE Maryland B. COUNTY 601			
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 23 N. Ellwood Avenue			
5. SEX A	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/2/13	9. AGE (In years lost birthday) 57	10. Under 1 Yr. Months	11. Under 24 Hrs. Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Frederick Liebau				14. MOTHER'S MAIDEN NAME Minnie Deichgraben			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 276-09-7388		17. INFORMANT Mrs. Catherine C. Liebau ADDRESS 23 N. Ellwood Ave	
18. 4/10/71 CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE CARDIOGENIC SHOCK 1 HR.			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(B) Myoc. Infarct 1 DAY			
ANTECEDENT CAUSES				(C) Arteriosclerotic heart dis. YRS			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 2/1				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that the (this hospital) attended the deceased from 4/29 19 71 to 4/30 19 71 that the (we) last saw the deceased alive on 4/30 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. We (We) (did) did not view the body after death.							
23A. SIGNATURE Juan M. Pardo				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4/30/71	
23C. PHYSICIAN'S NAME (Type) JUAN M. PARDO MD.				23D. ADDRESS MGH 827 Linden Ave. Balt			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/4/71		24C. NAME OF CEMETERY OR CREMATORY Bell Air Memorial Gardens		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 4 1971		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR John A. Moran, Inc.		ADDRESS 3000 E. Baltimore St	

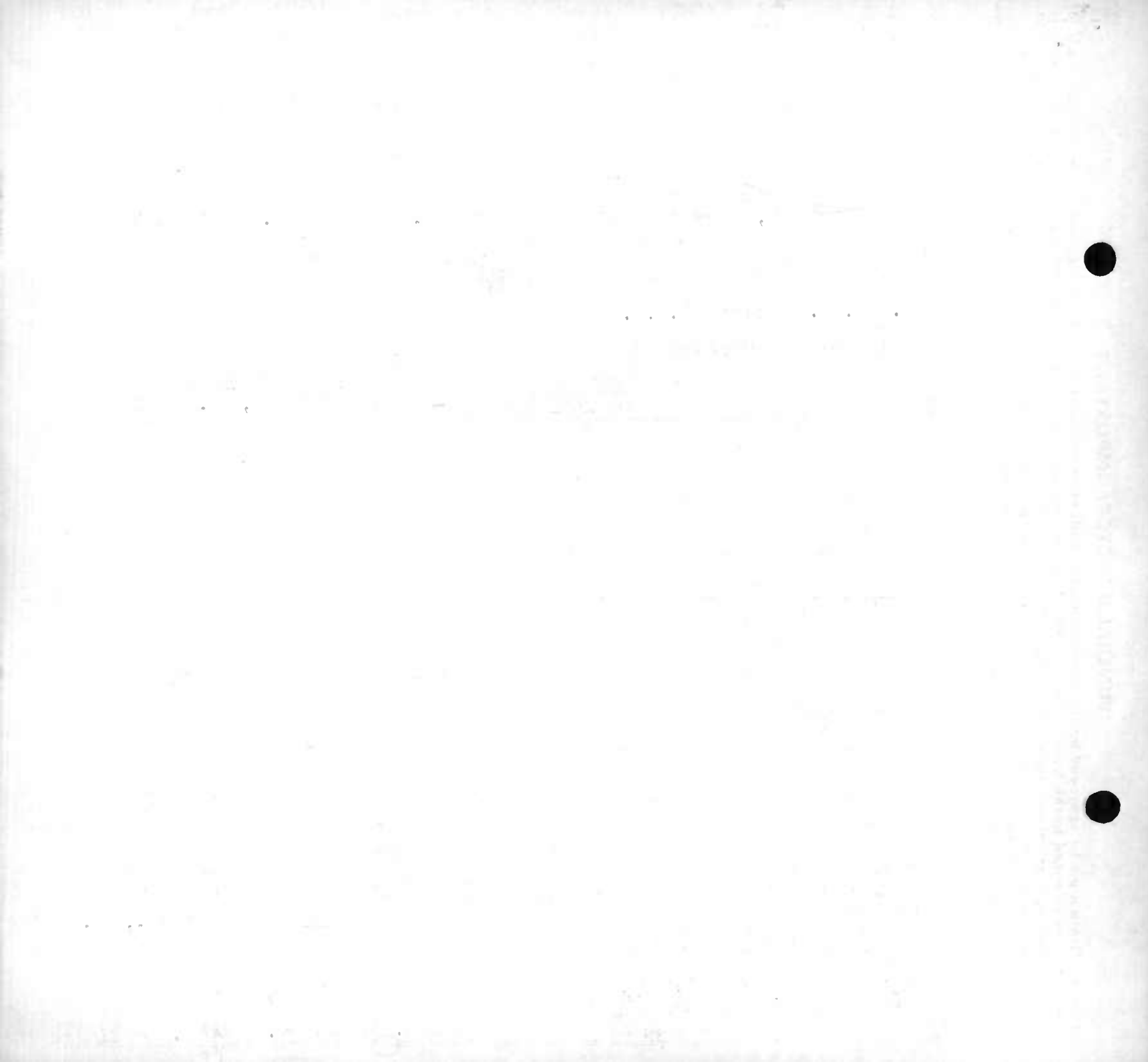


BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

BIRTH NO. <u>B-560</u>		1. NAME OF DECEASED (Type or Print) <u>Oscar N. Buhner</u>		2. DATE AND HOUR OF DEATH <u>5/1/71</u> <u>17:45 P.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>31</u> <u>BALTIMORE CITY HOSPITALS</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>				A. STATE <u>Maryland</u> B. COUNTY <u>2664</u>	
				C. CITY OR TOWN <u>Baltimore</u>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>3424 E. Baltimore St. 21224 007</u>	
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-6-92</u>	9. AGE (in years last birthday) <u>78</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. R. R. Forman Pa. R. R.</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>XXXXXXXXX Karl Buhner</u>				14. MOTHER'S MAIDEN NAME <u>Catherine</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>717-07-7128</u>		17. INFORMANT <u>4940 Eastern Avenue</u> ADDRESS <u>BCH-Records Baltimore, Md. 21224</u>	
18. <u>162.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u> <u>2 mo. +</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>May 1</u> 19 <u>71</u> to <u>May 1</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>May 1</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Dwight Cramer</u> DEGREE				23B. DATE SIGNED <u>5/1/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dwight Cramer</u> DEGREE				23D. ADDRESS <u>4940 Eastern Avenue Balto., Md. 21224</u> <u>Balt. City Hosp.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/3/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Parkwood Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 4 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. [unclear]</u>		25C. FUNERAL DIRECTOR <u>John A. Moran, Inc. 3000 E. Baltimore St.</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 4262

BIRTH NO.

1. NAME OF DECEASED <u>SUSIE</u> (Type or Print) GUZZIE WELSH				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>MARYLAND GENERAL HOSPITAL</u>				3. DATE PRONOUNCED DEAD Month Day Year Hour <u>April 29, 1971</u> <u>2:28 P.M.</u>	
6. SEX <u>Female</u>		7. RACE <u>White</u>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1206</u>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <u>5-1-1897</u>		10. AGE (In years last birthday) <u>73</u> 84		E. STREET AND NUMBER <u>2108 N. Charles Street</u>	
11. BIRTHPLACE (State or foreign country) <u>Salem, West Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Thomas H. Lowther</u>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		14B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		15. MOTHER'S MAIDEN NAME <u>Lucy H. Heflin</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		17. SOCIAL SECURITY NO. <u>235-12-6274</u>		18. INFORMANT <u>Mrs. Dorothy Alex 1107 Demarcay Way, Balto, Md.</u>	
19. <u>E 8/18/71</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH <u>Multiple Injuries</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <u>4-29-71</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <u>yes</u>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Street</u>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <u>21st and Maryland Avenue</u>	
22D. TIME OF INJURY (APPROX.) <u>4-29-71</u> <u>P.M.</u>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <u>Hit by falling tree (Auto-accident)</u>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Werner U. Spitz</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>Werner U. Spitz, M.D.</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>4/30/71</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-3-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Belair Memorial Gar. Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Belair, Harford Co. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 4 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Galt, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Lassahn Funeral Home 7401 Belair Rd. 21236</u>			

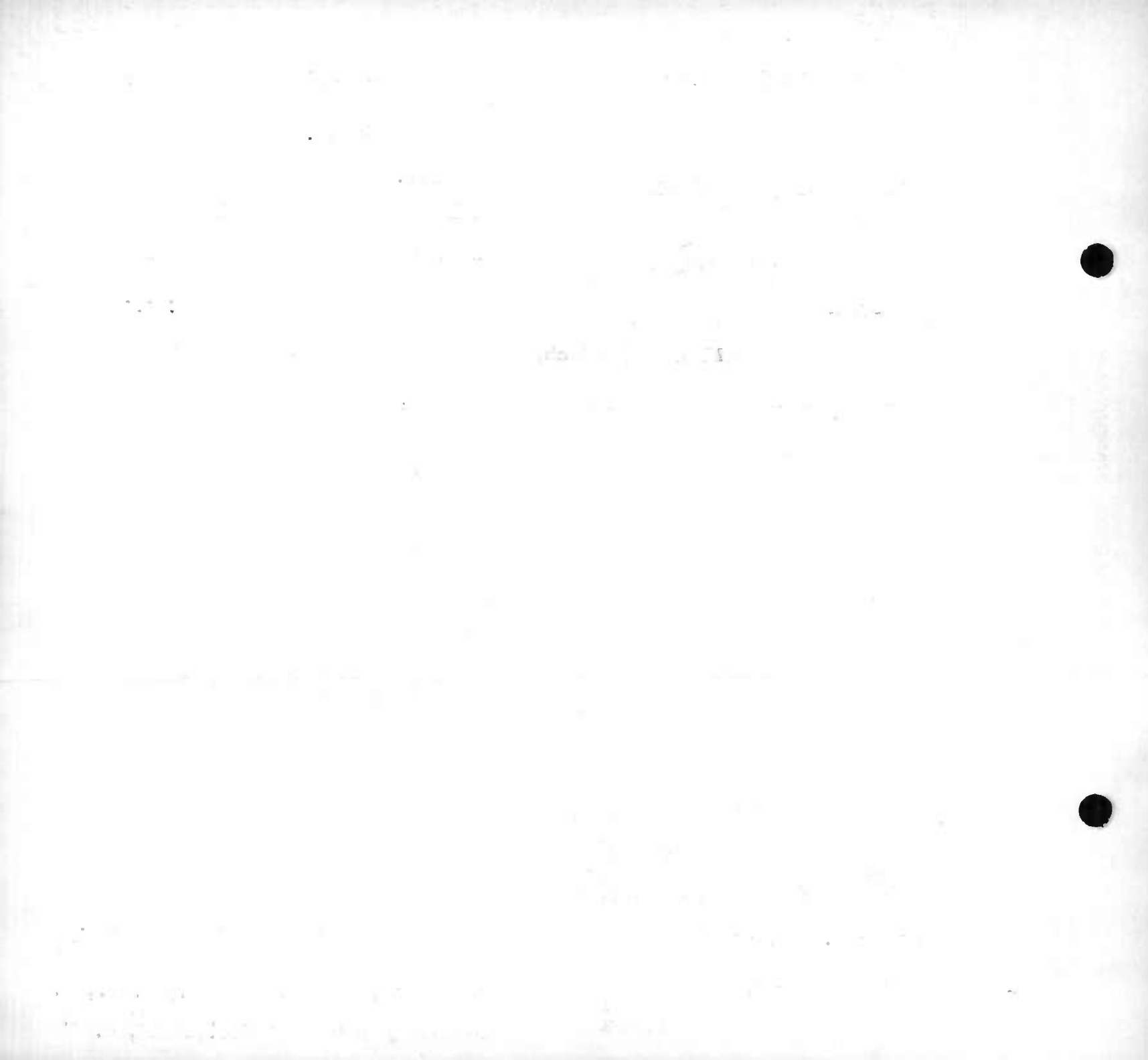
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WALTON & CO

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
7-563 71 4263		71 4263		71 4263	
1. NAME OF DECEASED (Type and Print) Finnerty Girl Barbara		2. DATE AND HOUR OF DEATH 4-29-71 2:59 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue		A. STATE MD		B. COUNTY	
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 4-25-71		9. AGE (In years last birthday) NB		10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.			
13. FATHER'S NAME Roland Bollach (Bollach)		14. MOTHER'S MAIDEN NAME BARBARA Finnerty			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS RECORDS: 4940 EASTERN AVENUE 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANOXIA RESPIRATORY DISTRESS SYNDROME PREMATURITY		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 4/29/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/25/71 19 71 to 4/29 19 71 that (I) (we) last saw the deceased alive on 4/29/71 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Peter R. Holbrook		23B. DATE SIGNED 4/29/71			
23C. PHYSICIAN'S NAME (Type) Peter R. Holbrook		23D. ADDRESS 4940 Eastern Avenue, Baltimore, Md. Baltimore City Hospitals 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-3-71		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery	
24D. LOCATION (City, town, or county) (State) 7225 Eastern Blvd., Ba. Co., Md.		25A. DATE REC'D BY HEALTH DEPT. MAY 4 1971		25B. NAME OF REGISTRAR Charles J. Gailer	
25C. FUNERAL DIRECTOR 901 S. Conkling St. Balto., 21224, Md.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 4-525 71 4264		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X REG. NO. 71 4264	
1. NAME OF DECEASED (Type or Print) LEROY J. HENNIGAN			2. DATE AND HOUR OF DEATH APRIL 29, 1971 12:05 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MARYLAND GENERAL HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTO. C. CITY OR TOWN DUNDALK D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 129 WILLOW SPRING RD, #21222		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/16/02	9. AGE (In years last birthday) 68	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOORMAN			10B. KIND OF BUSINESS OR INDUSTRY BALTO. CIVIC CENTER		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME CHARLES HENNIGAN		
14. MOTHER'S MAIDEN NAME MAMIE MCNEW			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 316-01-7035			17. INFORMANT MARY T. HENNIGAN		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ACUTE RENAL FAILURE					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 4/26/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED VASCULAR DISEASE		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR	
22. I certify that (I) (this hospital) attended the deceased from April 19 1971 to April 29 1971 that (I) (we) last saw the deceased alive on April 29 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Charles M. Harrison, M.D.				23B. DATE SIGNED 4/29/71	
23C. PHYSICIAN'S NAME (Type) CHARLES M. HARRISON M.D.				23D. ADDRESS Maryland General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5-3-71		24C. NAME OF CEMETERY OR CREMATORY SACRED HEART CEM.	
24D. LOCATION (City, town, or county) (State) 7401 GERMAN HILL RD., BALCO, MD.		25A. DATE TESTED BY HEALTH DEPT. MAY 1 1971			
25B. NAME OF REGISTRAR Robert E. J. J. J.		25C. FUNERAL DIRECTOR Charles S. J. J.		25D. ADDRESS 901 S. CONKLING ST. BALTO., 21224, MD.	

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HOSPITAL

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH											
REG. NO. [REDACTED]											
T-020		71		4265		71		4265		950 AM	
1. NAME OF DECEASED (Type or Print) <u>Marian P. Thomas</u>						2. DATE AND HOUR OF DEATH <u>4/29/71</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTIMORE</u>					
FULL NAME OF HOSPITAL OR INSTITUTION <u>48 MGH.</u>						C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? <u>YES</u>					
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)						E. STREET AND NUMBER <u>3009 Dunleer Rd. - Baltimore</u>					
5. SEX <u>F</u>		6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-24-15</u>		9. AGE (in years last birthday) <u>55</u>		10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HW</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>none</u>				11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13. FATHER'S NAME <u>THOMAS L. PURCELL</u>						14. MOTHER'S MAIDEN NAME <u>LYDIA MILLER</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>OSCAR T. THOMAS</u> <u>face sheet</u> <u>HUSBAND</u>				ADDRESS <u>#4 ABOVE</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>BRONCHOPNEUMONIA</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>COAD.</u> <u>PULMONARY EMPHYSEMA</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19A. DATE OF OPERATION <u>3-02</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>3-02</u> 19 <u>71</u> to <u>4/29</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>4/29</u> 19 <u>71</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>Maneetwala</u>						23B. DATE SIGNED <u>4/29/71</u>				23C. PHYSICIAN'S NAME (Type) <u>MANEETWALA</u>	
23D. ADDRESS <u>MGH</u>						23E. DEGREE					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>5/1/1971</u>		24C. NAME of CEMETERY or CREMATORY <u>DRUID RIDGE</u>		24D. LOCATION <u>PIRESVILLE, MD.</u>		(City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 4 1971</u>				25B. NAME OF REGISTRAR <u>John E. Taylor, M.D.</u>				25C. FUNERAL DIRECTOR <u>W. Brooks Bailey, Rockville, Md.</u>			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-424 71 4266		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 4266	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) BLACKWELL Sidney		2. DATE AND HOUR OF DEATH 4-28-71	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Lutheran Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 704		M.	
FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital		C. CITY OR TOWN Balti.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE		6. RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 7-24-05		9. AGE (in years last birthday) 65		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Railroad	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? UNITED STATES		13. FATHER'S NAME William Henry Blackwell	
14. MOTHER'S MAIDEN NAME Sadie Butler		15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-03-1107	
17. INFORMANT Mary Blackwell		ADDRESS 1838 E. Madison St.		18. CAUSE OF DEATH 591X1	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) (A) IMMEDIATE CAUSE Chronic Renal Failure DUE TO, OR AS A CONSEQUENCE OF:		DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) Hydronephrosis DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (H) (this hospital) attended the deceased from 4-26 19 71 to 4-28 19 71 that (H) (we) last saw the deceased alive on 4-28 19 71 and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.	
23A. SIGNATURE Percival C. Smith		23B. DATE SIGNED 4-30-71		23C. PHYSICIAN'S NAME (Type) Dr. Percival C. Smith	
23D. ADDRESS Oakland Nursing Home		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-4-71	
24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Arbutus Md.		25A. DATE REC'D BY HEALTH DEPT. MAY 4 1971	
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ELLIOTT F. H.		ADDRESS 1129 N. Caroline St.	

1874-75

Wm. L. G. 1874-75
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Wm. L. G. 1874-75

Wm. L. G. 1874-75
- 25. 3. 1875
Wm. L. G. 1874-75

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 4267

BIRTH NO. 4-534 71 4267

1. NAME OF DECEASED (Type or Print) JUANITA (HUNTHY) Huntley		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> April 29, 1971 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour April 29, 1971 8:35 P.M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 906			
6. SEX Female	7. RACE Negro	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore
9. DATE OF BIRTH 8-30-1930		10. AGE (In years lost birthday) 40	E. STREET AND NUMBER 1645 Chilton Street
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME Walter Wright
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser		14B. KIND OF BUSINESS OR INDUSTRY London Town	15. MOTHER'S MAIDEN NAME Mammie Louis
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	18. INFORMANT ADDRESS Mrs. Rosa Porter 342 Ilchester
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION 2			20B. CONDITION FOR WHICH OPERATION WAS PERFORMED
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	22F. HOW DID INJURY OCCUR?
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: [Signature] M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/30/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-4-71	24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park
24D. LOCATION (City, town, or county) (State) Baltimore Maryland		25C. FUNERAL DIRECTOR ADDRESS Arlington S. Phillips 1727 N. Monroe St.	
25A. DATE REC'D BY HEALTH DEPT. MAY 4 1971			

Letter from M.E.'s office

6-2-71

M.H.

ACADEMY BOND

8 1/2 x 11

VALLEY PAPER CO.

U.S.A.

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FUNERAL DIRECTOR: IMPORTANT

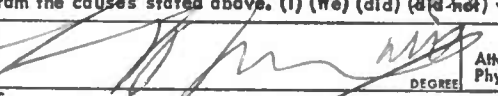
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 4268</u>	
T-400		71 4268		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>TILLEY, JOHN</u>		2. DATE AND HOUR OF DEATH <u>4-28-71</u> <u>3:30 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>BALTIMORE</u> B. COUNTY <u>Maryland</u>		C. CITY OR TOWN <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSP. OF BALTIMORE INC.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <u>2101 WHITTIER AVE.</u>	
5. SEX <u>M</u>	6. RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-7-1898</u>	9. AGE (In years lost birthday) <u>72 YR.</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
13. FATHER'S NAME <u>NOT AVAILABLE</u>		14. MOTHER'S MAIDEN NAME <u>EMMA GLENN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
15. Was Deceased ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>241-68-5703A</u>		17. INFORMANT <u>Mrs. Phyllis Tilley 2101 Whittier Ave.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Metastatic Carcinoma to Lungs, Ribs, Pelvis, Lumbar spine, thoracic spine, Sacral spine & possible</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Sec - To Ca of Prostate</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>undetermined</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>3-24-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Pain Rt. Shoulder Bone</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examined) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3-15-71</u> to <u>4-28-71</u> and that (I) (we) last saw the deceased alive on <u>4-28-71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>D. Emilio Suzara</u>		23B. DATE SIGNED <u>4-28-71</u>		23C. PHYSICIAN'S NAME (Type) <u>D. EMILIO SUZARA M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>		24B. DATE <u>4-30-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Vernon</u>	
24D. LOCATION <u>North Carolina</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 4 1971</u>		25B. NAME OF REGISTERAR <u>John S. Phillips</u>	
25C. FUNERAL DIRECTOR <u>Arlington S. Phillips</u>		25D. ADDRESS <u>1727 N. Monroe Street</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 4268</u>	
C-263 71 4269		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) COZART, MARVIN B.		2. DATE AND HOUR OF DEATH May 1, 1971 6:55 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland, Balto. City C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4324 Reisterstown Road			
5. SEX Male	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/26/23	9. AGE (In years last birthday) 47	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Order Clerk		10B. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Eddie Cozart		14. MOTHER'S MAIDEN NAME Catherine Sniper	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 237-28-3205		17. INFORMANT ADDRESS Madalene Sidemore Oxford, North Carolina	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Diabetes Mellitus Myocardial Infarction		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Septicemia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 0+	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Perirectal Abscess		(B) DUE TO, OR AS A CONSEQUENCE OF: Perirectal Abscess		2 wks	
(C) _____				2 wks	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 4/24/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Perirectal abscess		20A. AUTOPSY? (Yes or No) no	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ***		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 22 19 71 to May 1 19 71 that (I) (we) last saw the deceased alive on May 1 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED May 1, 1971	
23C. PHYSICIAN'S NAME (Type) Ernest O. Brown, M. D.		23D. ADDRESS 3414 Duval Avenue, Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 5-3-71		24C. NAME OF CEMETERY or CREMATORY Belton Creek	
24D. LOCATION Oxford, North Carolina					
25A. DATE REC'D BY HEALTH DEPT. MAY 4 1971		25B. NAME OF REGISTRAR Ernest O. Brown, M.D.		25C. FUNERAL DIRECTOR ADDRESS Arlington S. Phillips 1727 N. Monroe Street	



FUNERAL DIRECTOR: IMPORTANT

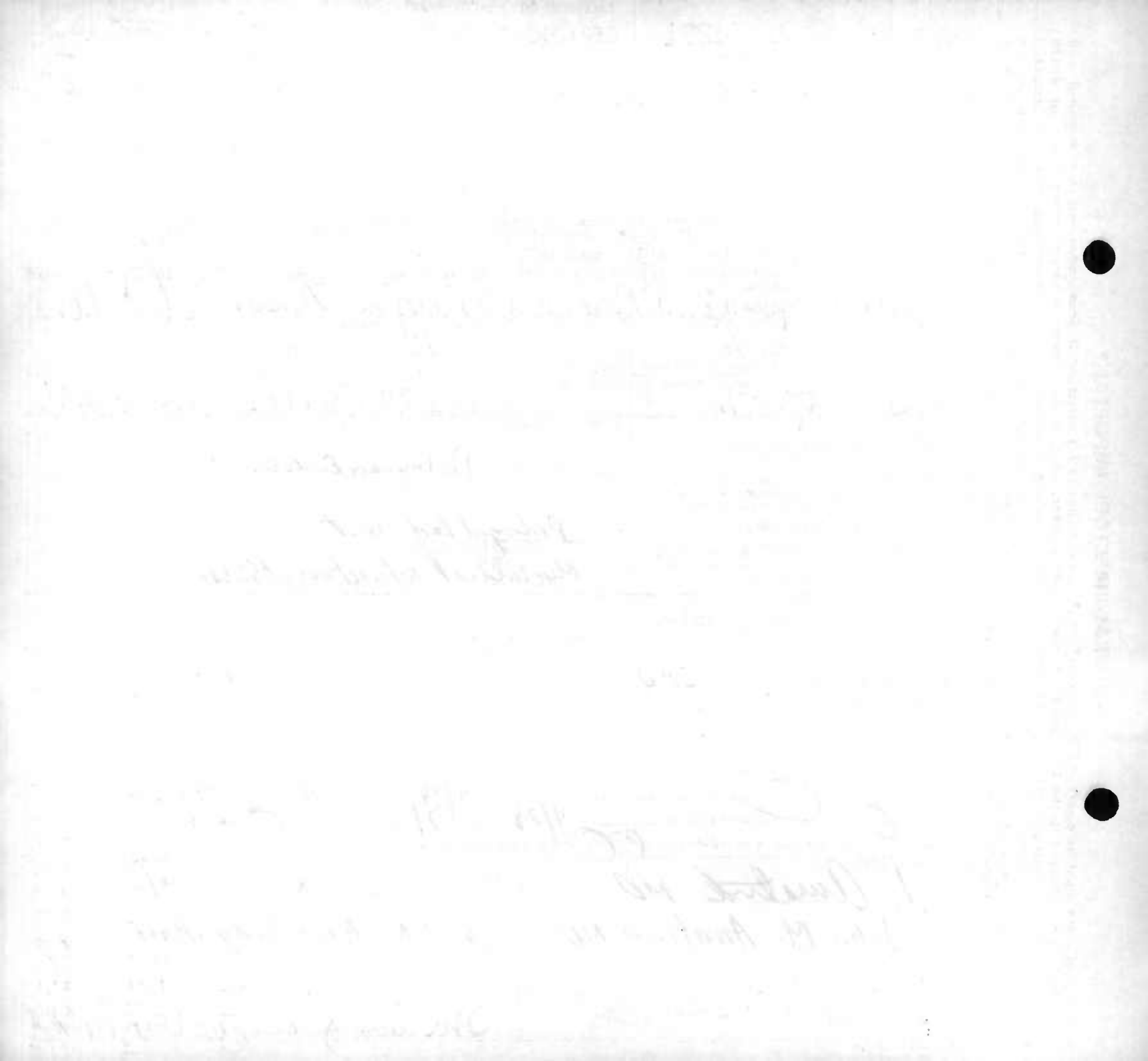
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 4270</u>	
BIRTH NO. <u>S-160</u>		71 4270			
1. NAME OF DECEASED (Type or Print) <u>Ella C. Sparrow</u>			2. DATE AND HOUR OF DEATH <u>April 29, 1971</u> <u>3:45 p. M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1505</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>002321 ANOKA AVE</u> <u>Baltimore Md.</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>2321 Anoka Avenue</u>		
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>2-19-28</u>	9. AGE (in years last birthday) <u>43</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>William Sparrow</u>		
14. MOTHER'S MAIDEN NAME <u>Ruth Blackstone</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>213-28-0113</u>			17. INFORMANT <u>Miss Leola Sparrow 6489 Meadowridge Rd</u>		
18. <u>153.81</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>CARCINOMATOSIS</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>CARCINOMA of Colon</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>6 mos</u>
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <u>Jan '71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CA of colon</u>		20A. AUTOPSY? (Yes or No) <u>no</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>9-11</u> 19 <u>70</u> to <u>4-29</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>4-29</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>5/3/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>G. Franklin Phillips MD</u>				23D. ADDRESS <u>558 Mc Mahon St. Balt. Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-3-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem. Pk.</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 4 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Jackson, MD.</u>		25C. FUNERAL DIRECTOR <u>Arlington S. Phillips 1727 N. Monroe Street</u>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

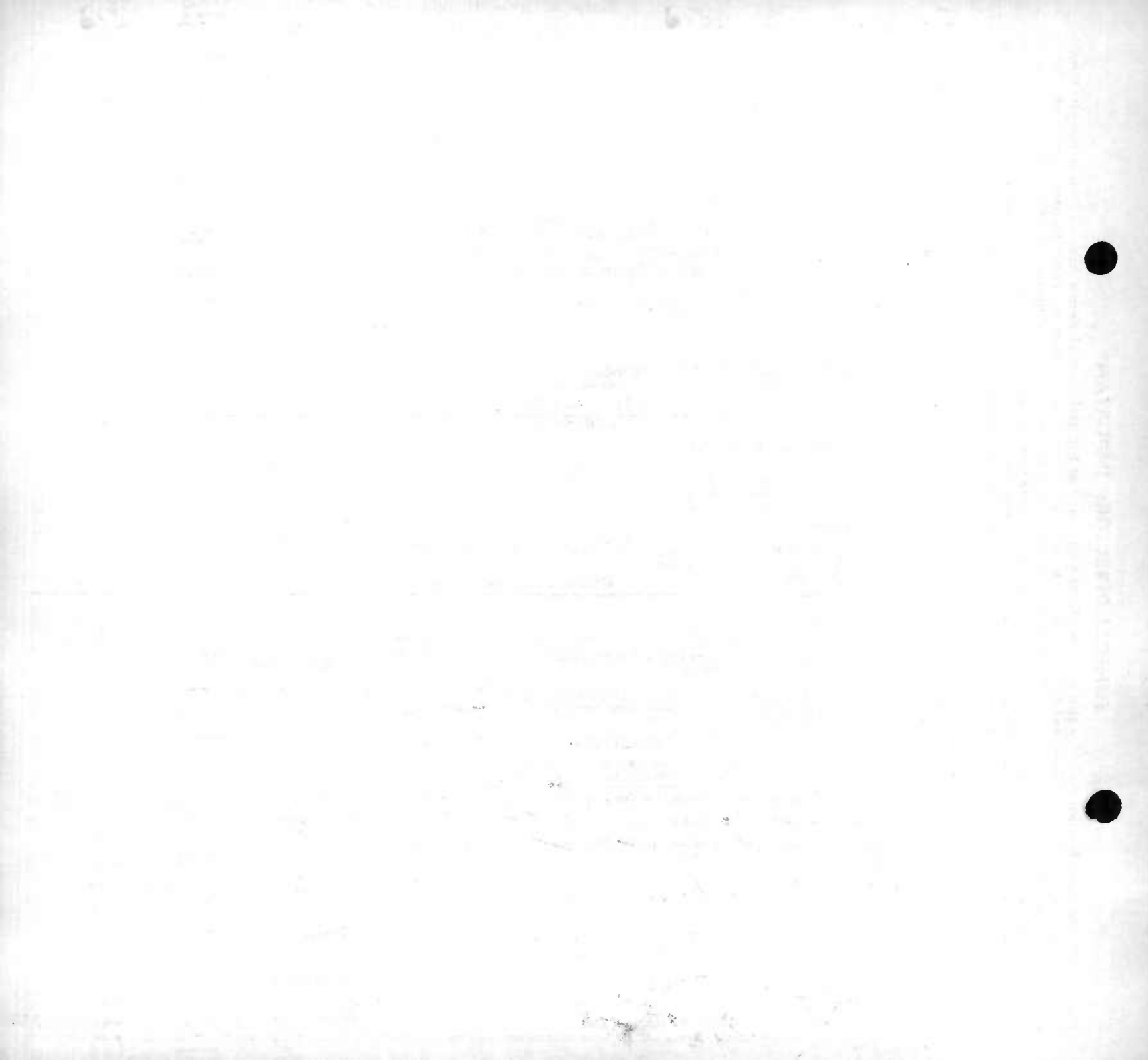
BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. <u>71 4271</u>	
BIRTH NO. <u>K-460</u> <u>71 4271</u>				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>KELLER, William</u>				2. DATE AND HOUR OF DEATH <u>4/28/71</u> <u>12 midnight</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 The Johns Hopkins Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Anne Arundle</u> <u>5210</u> C. CITY OR TOWN <u>Annapolis</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>810 Spa Road</u>			
5. SEX <u>Male</u>		6. RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/7/17</u>	
9. AGE (in years last birthday) <u>53</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Med. Commissioner U.S. Naval Acad</u>		11. BIRTHPLACE (State or foreign country) <u>Miss.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Keller</u>				14. MOTHER'S MAIDEN NAME <u>Marilda Martin</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>yes</u> <u>WW II</u>				16. SOCIAL SECURITY NO. <u>W.W. II</u>		17. INFORMANT <u>Magie M. Keller - Anna. Md.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Pulmonary Embolism</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Prolonged bed rest</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial infarction, ASCVD</u> (C)			
19. DATE OF OPERATION <u>3 4/20/71</u>				19A. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CAO</u>			
20A. AUTOPSY? (Yes or No) <u>Yes</u>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>4/19</u> <u>19 71</u> to <u>4/28</u> <u>19 71</u> that (I) (we) last saw the deceased alive on <u>4/28</u> <u>19 71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>J. Amatruda MD</u>				23B. DATE SIGNED <u>4/29/71</u>		23C. PHYSICIAN'S NAME (Type) <u>John M. Amatruda MD</u>	
23D. ADDRESS <u>601 N. Broadway, Balt, Md.</u>				23E. FUNERAL DIRECTOR <u>William Sekse, II - Annap. Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/3/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Fine Lawn Mem. Pk.</u>		24D. LOCATION (City, town, or county) (State) <u>Annapolis A.D. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 4 1971</u>		25B. NAME OF REGISTRAR <u>Robert J. ...</u>		25C. ADDRESS <u>...</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

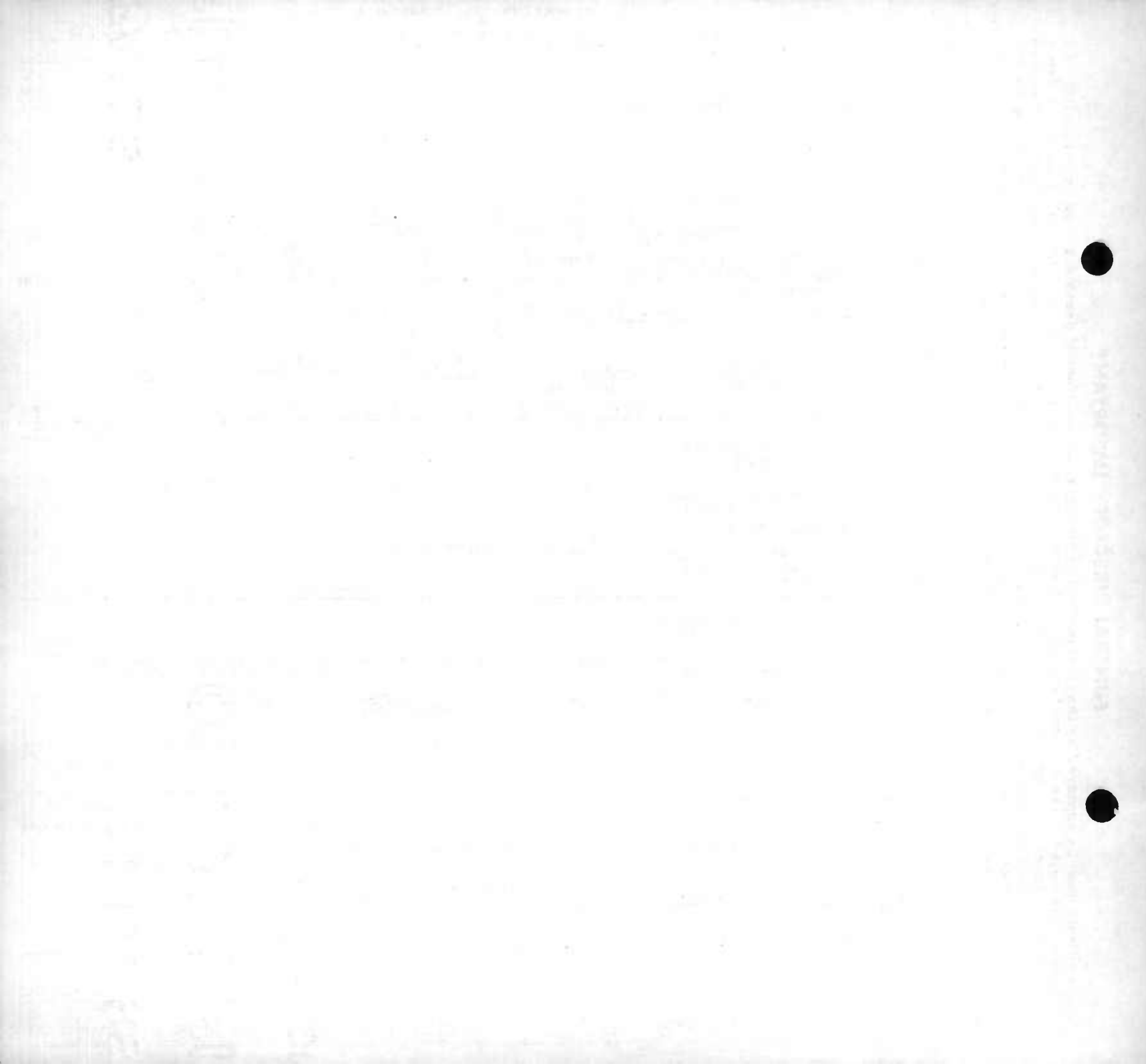
<div style="display: flex; justify-content: space-between;"> E-640 71 4272 </div>		<div style="display: flex; justify-content: space-between;"> BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH </div>		<div style="display: flex; justify-content: space-between;"> 71 4272 REG. NO. </div>	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>Edgar L. Early</u>		2. DATE AND HOUR OF DEATH <u>April 30, 1971</u> <u>10 p.m.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>00 2939 Belmont Avenue</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1607</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2939 Belmont Avenue</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-6-1889</u>	9. AGE (In years last birthday) <u>81</u>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Technician</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Westcot & Dennon</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Lewis Early</u>			
14. MOTHER'S MAIDEN NAME <u>Betty ?</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>226-16-8683A</u>		17. INFORMANT ADDRESS <u>Eliar Early 2939 Belmont Avenue</u>			
18. CAUSE OF DEATH <u>412.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE <u>Hypertensive Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Dissection</u> (B) <u>Coronary Artery Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: <u>10 years</u> (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		(If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Mar 1968</u> to <u>Apr 30 1971</u> that (I) (we) last saw the deceased alive on <u>14 Apr 1971</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Simon H. Carter Jr.</u>		23B. DATE SIGNED <u>3 May 71</u>		23C. PHYSICIAN'S NAME (Type) <u>Simon H. Carter Jr.</u>	
23D. ADDRESS <u>M. D. 4215 Park Heights Avenue</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>5-5-1971</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
25A. DATE RECD BY HEALTH DEPT. <u>MAY 4 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>NUTTER FUNERAL HOME 3035 W. NORTH AVE</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

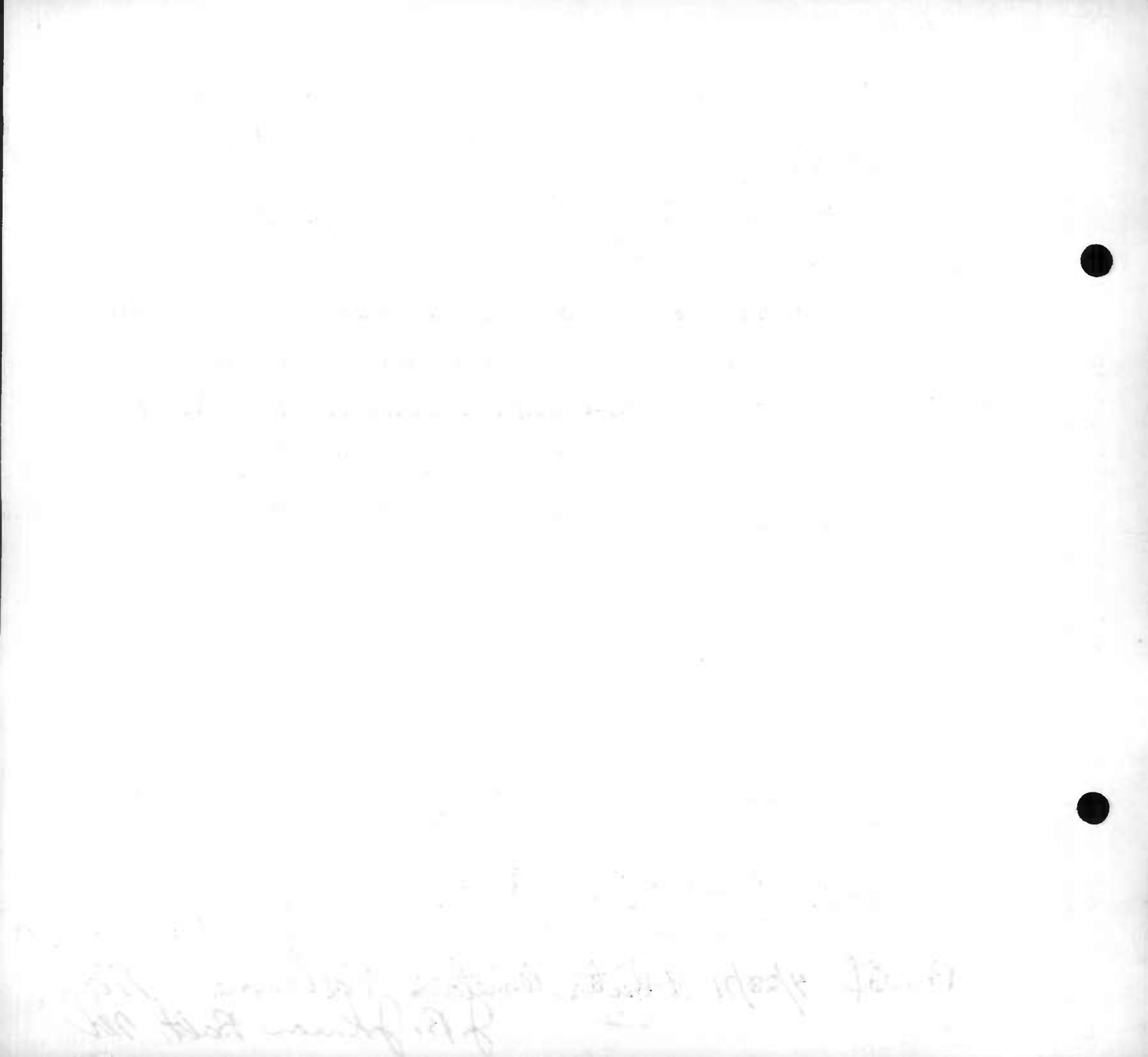
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 4273</u>	
R-534 71 4273 BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>Melvin T. Randolph</u>		CERTIFICATE OF DEATH 2. DATE AND HOUR OF DEATH <u>April 29, 1971</u> <u>5:30</u> <u>P.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>42 Sinai Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1303</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2347 Druid Hill Avenue</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-30-1902</u>	9. AGE (In years last birthday) <u>68</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief Engineer</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief Engineer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Balto. School System</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John R. Randolph</u>		14. MOTHER'S MAIDEN NAME <u>Dora E. Hachett</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>No</u>		16. SOCIAL SECURITY NO. <u>220-20-7438</u>		17. INFORMANT <u>A Mrs. Viola E. Randolph</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>41231</u> CAUSE OF DEATH <u>Arteriosclerotic Heart Disease</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 1968</u> to <u>April 1971</u> that (I) was last saw the deceased alive on <u>April 18</u> 19<u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) was <u>did</u> (did not) view the body after death.					
23A. SIGNATURE <u>Roland T. Smoot</u>				23B. DATE SIGNED <u>4/30/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Roland T. Smoot</u>				23D. ADDRESS <u>M. D. 2300 Garrison Blvd.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-3-1971</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Memorial Park</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Co. Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 4 1971</u>			
25B. NAME OF REGISTRAR <u>Rolland T. Smoot</u>		25C. FUNERAL DIRECTOR <u>NUTTER FUNERAL HOME 3035 W. NORTH AVE.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

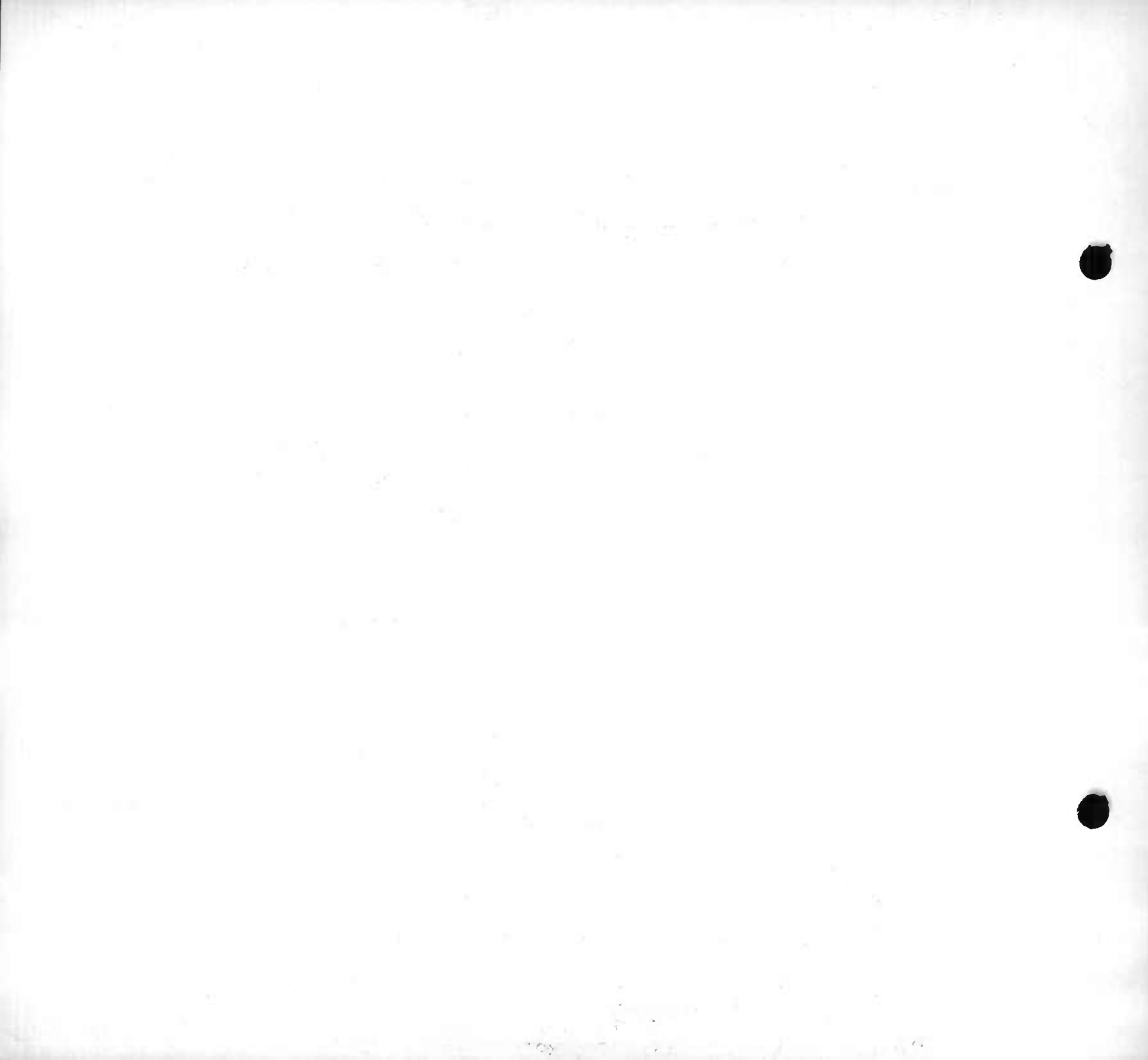
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4224	
4-463 71 4224				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Alice Hilliard</u>		2. DATE AND HOUR OF DEATH <u>APRIL 23 1971 3:15 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Mt Sinai Nursing Home</u> <u>90 4613 Park Heights Ave</u> <u>Balto MD 21215</u>			A. STATE <u>Maryland</u> B. COUNTY <u>2710</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>5302 St Georges Ave</u>		
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-26-84</u>	9. AGE (in years last birthday) <u>87</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher (Ret)</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>School System</u>		11. BIRTHPLACE (State or foreign country) <u>S. CAROLINA</u>	
13. FATHER'S NAME <u>Wearry Johnson</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>239-62-0611</u>		17. INFORMANT <u>Ben Crawford</u> ADDRESS <u>B.H. Md.</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>4123 I</u> <u>Acute Pulmonary Congestion & lungs</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>arteriosclerotic Heart Disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>6 weeks</u>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) _____
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>april 17 1971</u> to <u>april 23 1971</u> that (I) (we) last saw the deceased alive on <u>April 23 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Manuel Levin MD</u>			23B. DATE SIGNED <u>4/24/71</u>		23C. PHYSICIAN'S NAME (Type) <u>MANUEL LEVIN MD</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>4/28/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Abraham Lincoln Cemetery</u>
24D. LOCATION (City, town, or county) <u>Baltimore</u>			24E. STATE <u>MD</u>		24F. FUNERAL DIRECTOR <u>J. B. Johnson</u> ADDRESS <u>Balto MD</u>
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 4 1971</u>			25B. NAME OF REGISTRAR <u>J. B. Johnson</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 4275</u>	
<div style="display: flex; justify-content: space-between;"> <u>S-300</u> <u>71 4275</u> CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) <u>William H. Scott</u>			2. DATE AND HOUR OF DEATH <u>4-30-71</u> <u>9:30 P</u> ^{M.}		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>90 Mt Sinai Nursing Home</u> <u>4613 Park Heights Ave</u> <u>Balto Md 21215</u>			A. STATE <u>Maryland</u> B. COUNTY <u>908</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1907 Aisquith Street</u>		
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-1-05</u>	9. AGE (in years last birthday) <u>68</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STEELWORKER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>BETHLEHEM STEEL</u>		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME		
14. MOTHER'S MAIDEN NAME <u>POLLY COLE</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>226-12-6889</u>			17. INFORMANT ADDRESS <u>MRS CORA A. SCOTT 1907 AISQUITH ST.</u>		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Carcinoma of prostate</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>metastatic to lung & spine</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>none</u>			(B) DUE TO, OR AS A CONSEQUENCE OF: <u>none</u>		
(C) DUE TO, OR AS A CONSEQUENCE OF: <u>none</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from <u>Feb 16</u> 19 <u>71</u> to <u>April 30</u> 19 <u>71</u> that (1) (we) last saw the deceased alive on <u>April 30</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Manuel Levin MD</u>				23B. DATE SIGNED <u>4/30/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>MANUEL LEVIN M.D.</u>				23D. ADDRESS <u>6101 PARK HEIGHTS AVE BALTO MD 21215</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>5/5/71</u>		24C. NAME of CEMETERY or CREMATORY <u>MT AUBURN CEM.</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>		25A. DATE REC'D BY HEALTH DEPT. & STRA <u>MAY 4 1971</u>			
25C. FUNERAL DIRECTOR <u>W.M.C. MARCH</u>				ADDRESS <u>928 E. NORTH AVE</u>	



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71 4276 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 4276

1. NAME OF DECEASED (Type or Print) MONROE DILLOW & DELLUOMO		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> April 30, 1971 7:08 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Church Home and Hospital		3. DATE PRONOUNCED DEAD Month Day Year April 30, 1971 7:08 P.M.	
5. USUAL RESIDENCE (Where deceased lived: if institution: residence before admission) A. STATE Maryland B. COUNTY 202		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH JUNE 20 1952		10. AGE (In years last birthday) 18 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) BALTIMORE MD		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEAMAN		14B. KIND OF BUSINESS OR INDUSTRY —	
15. MOTHER'S MAIDEN NAME HAZEL WORKMAN		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO. 217-86-8098		18. INFORMANT HAZEL DELLUOMO 1115 REGESTER AVE	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral hypoxia and pneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Narcotism		DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 5-1-71			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE MAY 4 1971	
24C. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER CFM		24D. LOCATION (City, town, or county) (State) 4430 BELAIR RD BALTO MD	
25A. DATE REC'D BY HEALTH DEPT. MAY 4 1971		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR DIPPEL BROS INC 1800 E LOMBARD ST		ADDRESS	

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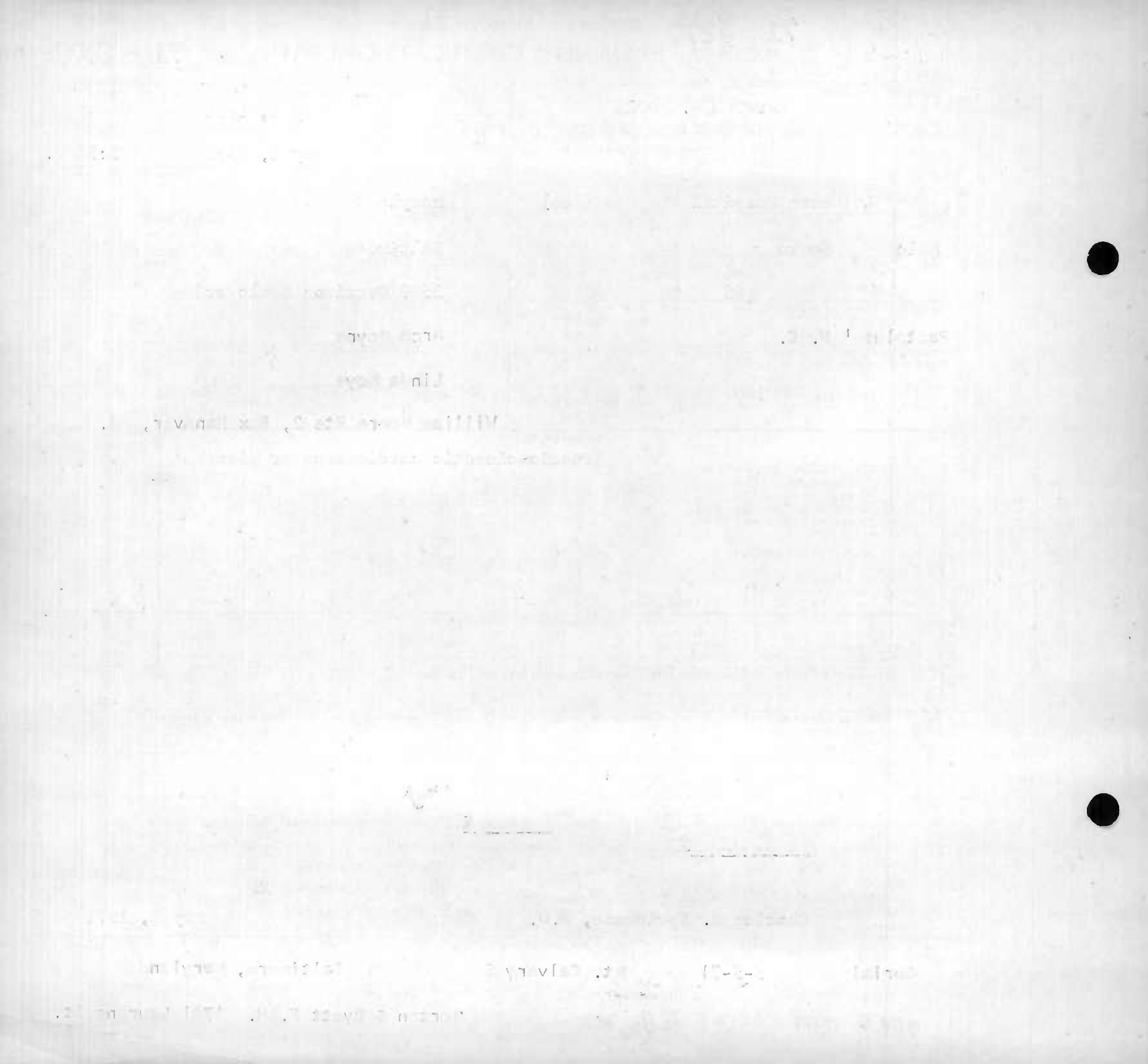
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 4277

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HAYWOOD W. MOORE		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year May 1, 1971		Hour 3:30 P.M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year May 1, 1971		Hour 3:30 P.M.
6. SEX Male		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH 65		10. AGE (In years last birthday) 65		11. BIRTHPLACE (State or foreign country) Pactolus, N. C.
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Arch Moyee		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
15. MOTHER'S MAIDEN NAME Linda Moyee		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.
18. INFORMANT William Moore Rte 2, Box Hanover, Md.		19. CAUSE OF DEATH Arteriosclerotic cardiovascular disease		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		22. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).
24. DATE OF OPERATION		25. CONDITION FOR WHICH OPERATION WAS PERFORMED		26. AUTOPSY? (Yes or No) Yes
27. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
30. TIME OF INJURY (APPROX.)		31. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		32. HOW DID INJURY OCCUR?
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE Charles S. Springate EXAMINER'S NAME (Type)		M.D. Charles S. Springate, M.D.		DATE SIGNED May 2, 1971
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-5-71		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary S
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. MAY 4 1971		25B. NAME OF REGISTRAR Robert E. J. Bay, M.D.
25C. FUNERAL DIRECTOR Morton & Dyett F. H.		25D. ADDRESS 1701 Laurens St.		



S-450

71 4278 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 4278

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Carrie Carey Sloan		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month 5 Day 3 Year 71 Hour 7:25 a. Estimated <input type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 311 N. Central Ave.		3. DATE PRONOUNCED DEAD Month 5 Day 3 Year 71 Hour 7:25 a.	
6. SEX female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto	
9. DATE OF BIRTH April 17, 1918		10. AGE (In years lost birthday) 52	
11. BIRTHPLACE (State or foreign country) Anderson, S. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Betty Sloan 311 N. Central Avenue		ADDRESS	
19. CAUSE OF DEATH 3039 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE Acute alcoholic intoxication DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) yes	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, MD EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 5/3/71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-8-71	
24C. NAME OF CEMETERY or CREMATORY Evergreen Cemetery		24D. LOCATION (City, town, or county) (State) Anderson, S. C.	
25A. DATE REC'D BY HEALTH DEPT. MAY 4 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Morton & Dyett F. H.		ADDRESS 1701 Laurens Street	

Letter from M.E.'s office

6-10-71

M.H.

Thompson

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 4278</u>	
<div style="display: flex; justify-content: space-between;"> A-352 71 4278 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) Adams, Laura		2. DATE AND HOUR OF DEATH 5/2/71 2AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Bolton Hill Nursing Home 1400 John St.-Balto. Md. 21217.		A. STATE Md. B. COUNTY 2001 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1910 W. Fayette St.			
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/15/1864	9. AGE (in years last birthday) 107	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Georgia	
13. FATHER'S NAME Unkown		14. MOTHER'S MAIDEN NAME Unkown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS James C. Thomas 1910 W. Fayette Street	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 18401 (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of Uterus (B) DUE TO, OR AS A CONSEQUENCE OF: (C)					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Generalized Atherosclerosis					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from April 13 19 71 to May 2 19 71 that (1) (we) lost saw the deceased alive on May 2 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Peter H Rheinstein, M.D.				23B. DATE SIGNED May 2, 1971	
23C. PHYSICIAN'S NAME (Type) PETER H. RHEINSTEIN		23D. ADDRESS BOLTON HILL NURSING HOME			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE 5-8-71	24C. NAME OF CEMETERY or CREMATORY New Hope Cemetery		24D. LOCATION (City, town, or county) (State) Clinton, S. C.	
25A. DATE REC'D BY HEALTH DEPT. MAY 4 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Morton J. Degett Adams	

1871 200

1871 200

1871 200

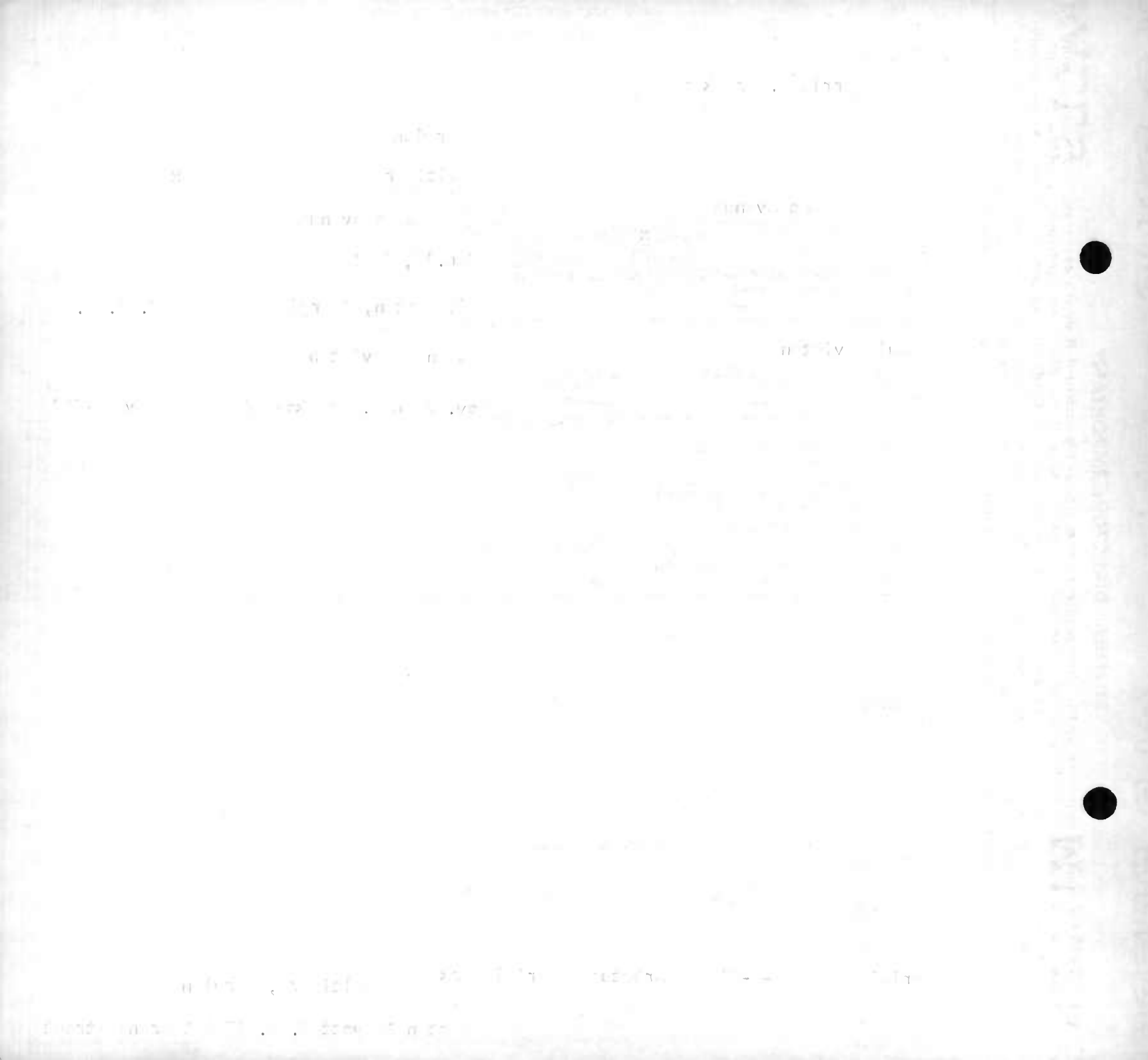
1871 200

1871 200

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

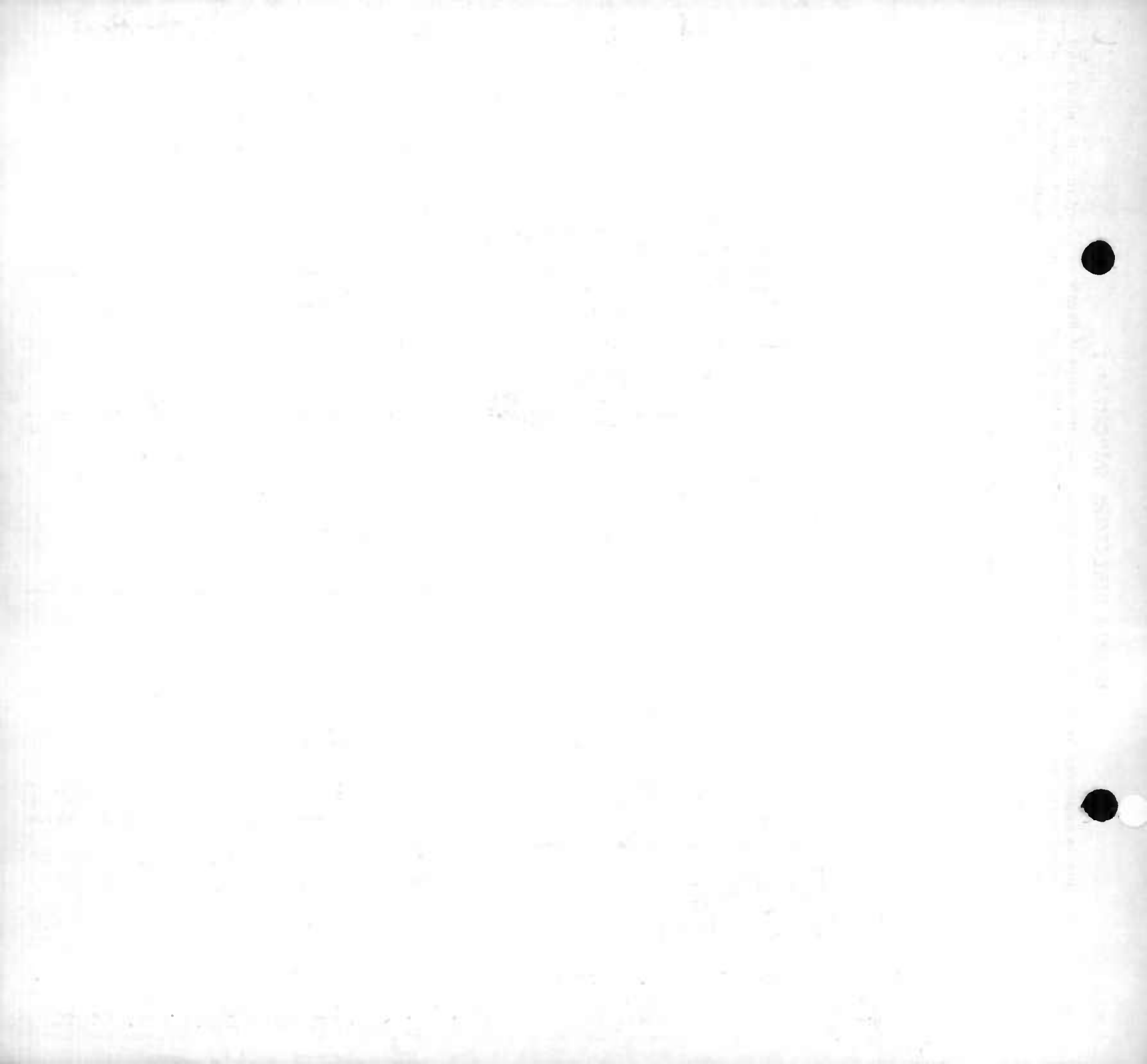
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 4280</u>	
B-622 71 4280 CERTIFICATE OF DEATH		1. NAME OF DECEASED (Type or Print) <u>Carrie D. Brookes</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u> <u>5506 Nome Avenue</u>		2. DATE AND HOUR OF DEATH <u>5/27/71</u> <u>2A</u> M. 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2831</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>5506 Nome Avenue</u>			
5. SEX <u>F</u>	6. RACE <u>B</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 16, 1902</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>00</u>		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <u>69</u>	
11. BIRTHPLACE (State or foreign country) <u>Thomaston, Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Paul Daviston</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Daviston</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Rev. John R. Brookes</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>410.9 I</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>—</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>		19A. DATE OF OPERATION <u>0</u>	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <u>—</u>		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>5/11</u> <u>1969</u> to <u>5/27</u> <u>1969</u> that (I) (we) last saw the deceased alive on <u>5/11</u> <u>1969</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Morton & Dyett F. H.</u>		23B. DATE SIGNED <u>5/31/71</u>		23C. PHYSICIAN'S NAME (Type) <u>—</u>	
23D. ADDRESS <u>—</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>5-6-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 4 1971</u>		25B. NAME OF REGISTRAR <u>—</u>		25C. FUNERAL DIRECTOR <u>Morton & Dyett F. H.</u>	
25D. ADDRESS <u>1701 Laurens Street</u>		VS 150-REV. 1/1/68			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
SHIELDS DELMOND F		05/02/1971		1:38 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL			A. STATE MARYLAND		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			B. COUNTY		
			C. CITY OR TOWN BALTIMORE		
			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 3032 GREENMOUNT AVENUE		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 06-08-1914	9. AGE (in years last birthday) 56	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSURANCE CO. MANAGER		10B. KIND OF BUSINESS OR INDUSTRY MAIL ROOM		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME CHARLES D. SHIELD		14. MOTHER'S MAIDEN NAME ALVA REITER		12. CITIZEN OF WHAT COUNTRY? (AMERICAN) U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY No. 212-10-3167		17. INFORMANT U.N. H. ADMISSION HISTORY	
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: METASTATIC CARCINOMA OF LIVER. PRIMARY PROBABLY LUNG		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 14/29/1971		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BILHVER OPERATIVE BIOPSY		20A. AUTOPSY (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 04-22-1971 to 05/2/1971 that (I) (we) lost saw the deceased alive on 05/02/1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Rau		23B. DATE SIGNED 05/02/1971		23C. PHYSICIAN'S NAME (Type) DR R. RAU MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-5-1971		24C. NAME of CEMETERY or CREMATORY Mt. Olivet Cemetery	
25A. DATE REC'D BY HEALTH DEPT. MAY 4 1971		25B. NAME OF REGISTRAR R. E. Fisher, R.D.		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212	



REG. NO. 71 4282

VS 151-REV. 1/1/68

MEDICAL CERTIFICATION

4/1/1941

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 4283

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) EUGENIA FOOTE		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> April 30, 1971 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 519 W. Presstman St.		3. DATE PRONOUNCED DEAD Month Day Year Hour P M. April 30, 1971 1:08 P	
6. SEX Female		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1403	
7. RACE Negro		C. CITY OR TOWN Baltimore	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH May 30, 1901		10. AGE (In years lost birthday) 69 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Calvert Co., Md.		12. CITIZEN OF WHAT COUNTRY? Andrew Abrams	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		14B. KIND OF BUSINESS OR INDUSTRY Betty Brown	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. Ms Grace	
18. INFORMANT Ms Grace		ADDRESS 519 Presstman St.	
19. 412.4 CAUSE OF DEATH Arteriosclerotic cardiovascular disease DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED 5-1-71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/5/71	
24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Westport (Baltimore) Md	
25A. DATE REC'D BY HEALTH DEPT. MAY 4 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Joseph Hines		ADDRESS 2222 W. Hubbard Ave.	

WALLACE ROORGE

4/20/60

4/20/60

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-200 4284				BALTIMORE CITY HEALTH DEPARTMENT		71 4284
BIRTH NO.				REG. NO.		
1. NAME OF DECEASED (Type or Print) <u>Dix, Lula</u>			2. DATE AND HOUR OF DEATH <u>4-27-71 7:30 P.</u>			M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>46 Lutheran Hospital</u>			A. STATE <u>Maryland</u>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Baltimore, Md. 21216</u>			B. COUNTY <u>1503</u>			
			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
			E. STREET AND NUMBER <u>1633 MORELAND AVE.</u>			
5. SEX <u>7</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-30-92</u>	9. AGE (in years last birthday) <u>79</u>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Luther Harris</u>			14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Elizabeth Bryant</u>	ADDRESS <u>Same</u>
18. <u>41241</u> CAUSE OF DEATH						
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Uremia</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <u>ASCVD - Dehydration</u> DUE TO, OR AS A CONSEQUENCE OF:			
(C)						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).						
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>4/27/71</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>4/27</u> 19 <u>71</u> to <u>4/27</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>4/27</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE <u>[Signature]</u>			23B. DATE SIGNED <u>4.27.71</u>			
23C. PHYSICIAN'S NAME (Type) <u>C. Gakuba</u>			23D. ADDRESS <u>Lutheran Hosp. 730 ASHBURTON ST. Balto, Md 21216</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-1-71</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Auburn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Westport (Baltimore) Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 4 1971</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>2222 W North Ave</u>

100

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14. 1000

J-552

71 4285

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 4285

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JANEY JENNINGS

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

003415 Cedar Dale Road

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

April 26, 1971

11:48 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

1511

6. SEX

Female

7. RACE

Negro

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

1904

10. AGE (in years
last birthday)

66

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

3415 Cedar Dale Road

11. BIRTHPLACE (State or foreign country)

Unknown

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14A. USUAL OCCUPATION (Give kind of work
done during most of working life even if retired)

Home maker

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Unknown

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Crownview St. Hospital, Crownview Md.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/27/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

5/5/71

24C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cemetery

24D. LOCATION

(City, town, or county)

(State)

Joseph P. Brooklyn, Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Joseph P. Rues 2422 W. North Ave.

MAY 4 1971

Public Health Dept.

WILLIAM RAPER

W/ALBURY - (P/O) 1914

25/11/1914

Remains of/11

1914

1914

FUNERAL DIRECTOR: IMPORTANT

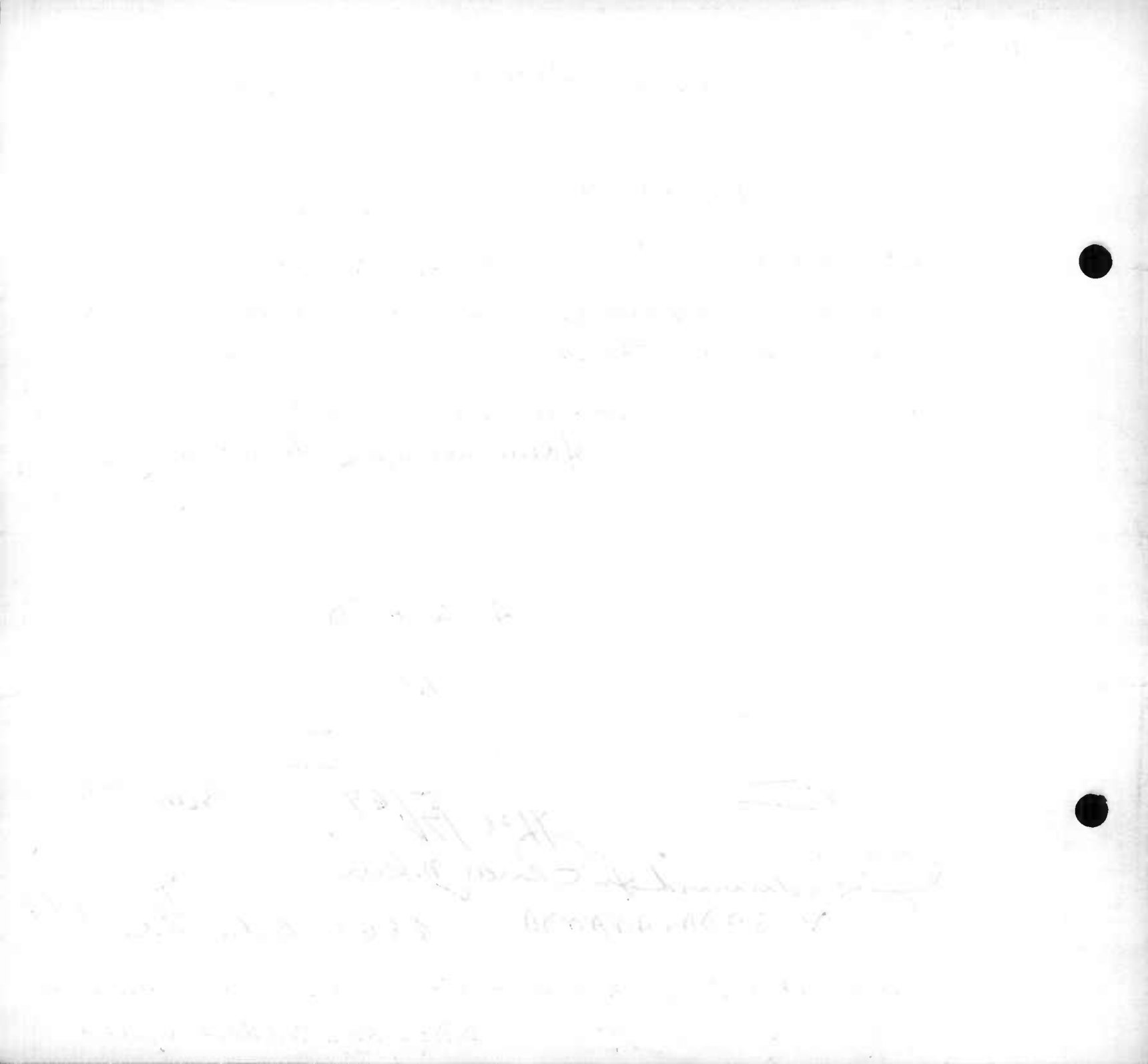
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-142 71 4286		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 4286	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) LOVELESS ETHEL		2. DATE AND HOUR OF DEATH MAY 2 ND 1971 11:40 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY		2544	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SOUTH BALTIMORE GENERAL HOSPITAL 43		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 6/18/96	
13. FATHER'S NAME WILLIAM CONNELLY		14. MOTHER'S MAIDEN NAME KATIE YEAGER		9. AGE (In years last birthday) 74	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-10-6581-D		11. BIRTHPLACE (State or foreign country) Md.	
17. INFORMANT ETHEL SZYMANSKI		ADDRESS 4233 AUDREY AV. NIECE		12. CITIZEN OF WHAT COUNTRY?	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) RENAL FAILURE ETC.		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. COMPLETE OBST. LEFT URETER		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). ANEMIA, CHF		(B) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/10/71 to 5/2/71 that (I) (we) last saw the deceased alive on 5/2/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE M.D. [Signature]		23B. DATE SIGNED 5/2/71	
23C. PHYSICIAN'S NAME (Type) DR. WEISS		23D. ADDRESS DEGREE		23E. FUNERAL DIRECTOR McCully FHV37 Palapane	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5/5/71		24C. NAME OF CEMETERY OR CREMATORY OAKLAWN CEM	
24D. LOCATION BALTO CO		24E. CITY, TOWN, OR COUNTY MD.		24F. STATE MD.	
25A. DATE REC'D BY HEALTH/DEPT. MAY 4 1971		25B. NAME OF REGISTRAR Robert E. Fisher, R.D.		25C. FUNERAL DIRECTOR McCully FHV37 Palapane	
25D. ADDRESS 71275					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

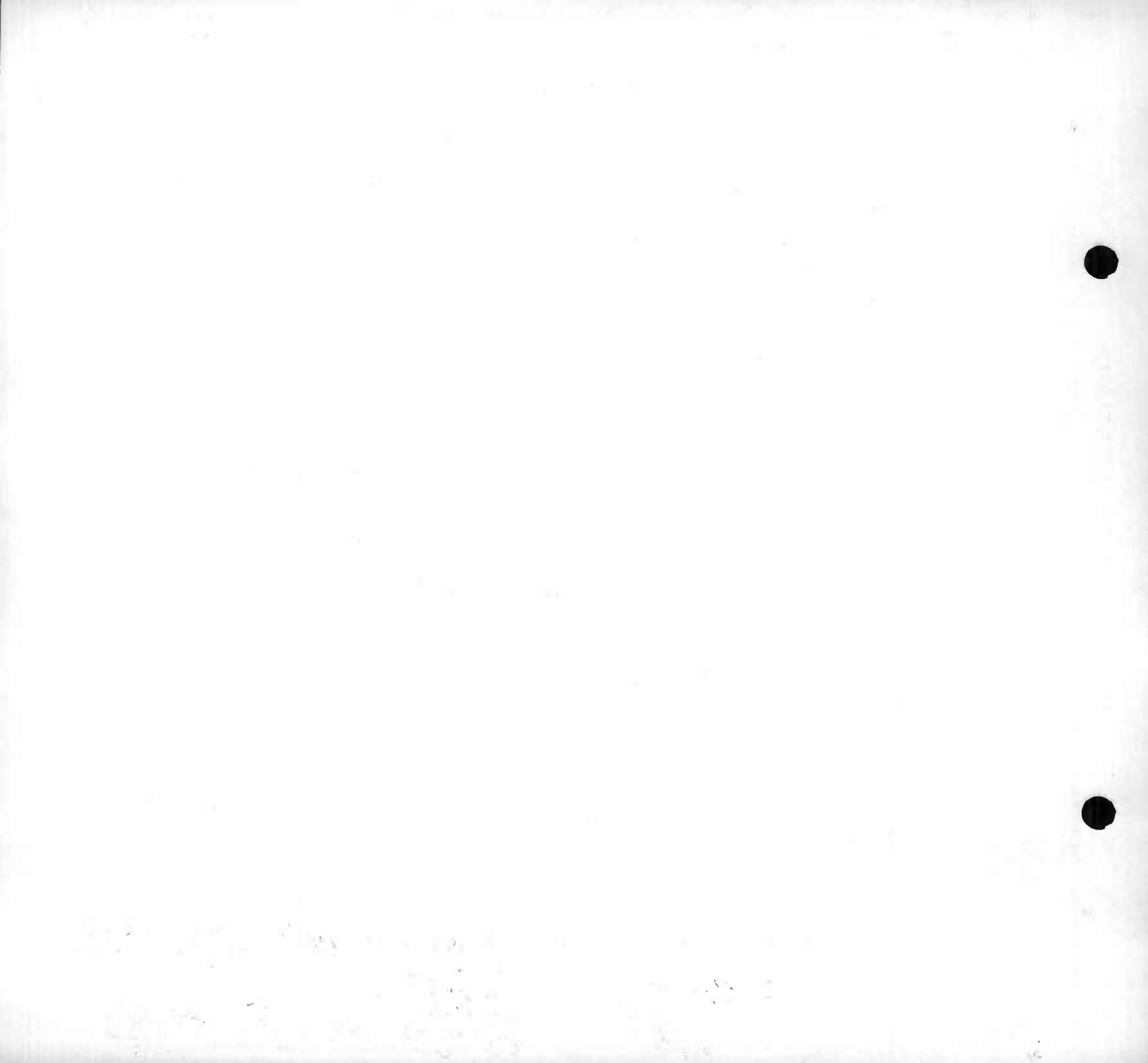
C-623		71 4287		BALTIMORE CITY HEALTH DEPARTMENT		71 4287	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
SVEN A. CHRISTENSEN				APRIL 29 1971 145 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 00 5527 WALTHER AVE				A. STATE MARYLAND			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY			
				C. CITY OR TOWN BALTIMORE			
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER 5527 WALTHER AVE.			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 29 1904	9. AGE (In years last birthday) 66	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BUYER		10B. KIND OF BUSINESS OR INDUSTRY HOUSEWARES		11. BIRTHPLACE (State or foreign country) LONDON ENGLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LAURITZ CHRISTENSEN				14. MOTHER'S MAIDEN NAME MAREN SORENSEN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 071-01-6619		17. INFORMANT MARY ANN CHRISTENSEN 5527 WALTHER AVE			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Adenocarcinoma Prostate				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 3/4 yrs			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				A. S. H. D.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) We		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5/26/69 to Present 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE V. S. ADARAYANDA				23B. DATE SIGNED 5/30/71			
23C. PHYSICIAN'S NAME (Type) V. S. ADARAYANDA				23D. ADDRESS 6801 Belair Rd			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE MAY 1 1971		24C. NAME of CEMETERY or CREMATORY PARK WOOD CEMETERY		24D. LOCATION (City, town, or county) (State) TAYLOR AVE BALTO MD	
25A. DATE REC'D BY HEALTH DEPT. MAY 4 1971		25B. NAME OF REGISTRAR J. J. J. J.		25C. FUNERAL DIRECTOR DIPPEL BROS.		25D. ADDRESS 7110 BELAIR ROAD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Underdetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-320		71 4288		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 4288		
1. NAME OF DECEASED (Type or Print) <u>GOETZ, EDWARD G</u>				2. DATE AND HOUR OF DEATH <u>Apr-28th 1971 2:30 AM</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>University Hosp. Balto.</u>				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTO.</u> (1516 Fernley Rd Balto 21218 Md)				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University Hosp. Balto.</u>				C. CITY OR TOWN <u>BALTO</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>4/19/04</u>		9. AGE (in years last birthday) <u>66</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REV.</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>ILLINOIS</u>		
13. FATHER'S NAME <u>MATTHIAS GOETZ</u>				14. MOTHER'S MAIDEN NAME <u>OTTEILIE ROSS</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
18. <u>1538 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Cardio resp failure</u> This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <u>2</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <u>YES</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u> NO				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardio resp failure</u> (B) <u>Coronary artery</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Ca Colon</u> (C) <u>Ca Colon</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>42 hrs.</u>		
MEDICAL CERTIFICATION								
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>4/13/71</u> 19 to <u>4/28/71</u> 19 that (I) (we) last saw the deceased alive on <u>4/28/71</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.								
23A. SIGNATURE <u>H. S. Ranganath, M.D.</u>				23B. DATE SIGNED <u>Apr. 28 1971</u>				
23C. PHYSICIAN'S NAME (Type) <u>H. S. RANGANATH, M.D.</u>				23D. ADDRESS <u>ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL</u>				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>4-30-71</u>		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, State, County) (State)		
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 4 1971</u>				25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>MORTUARY SERVICE - BCHO</u>		

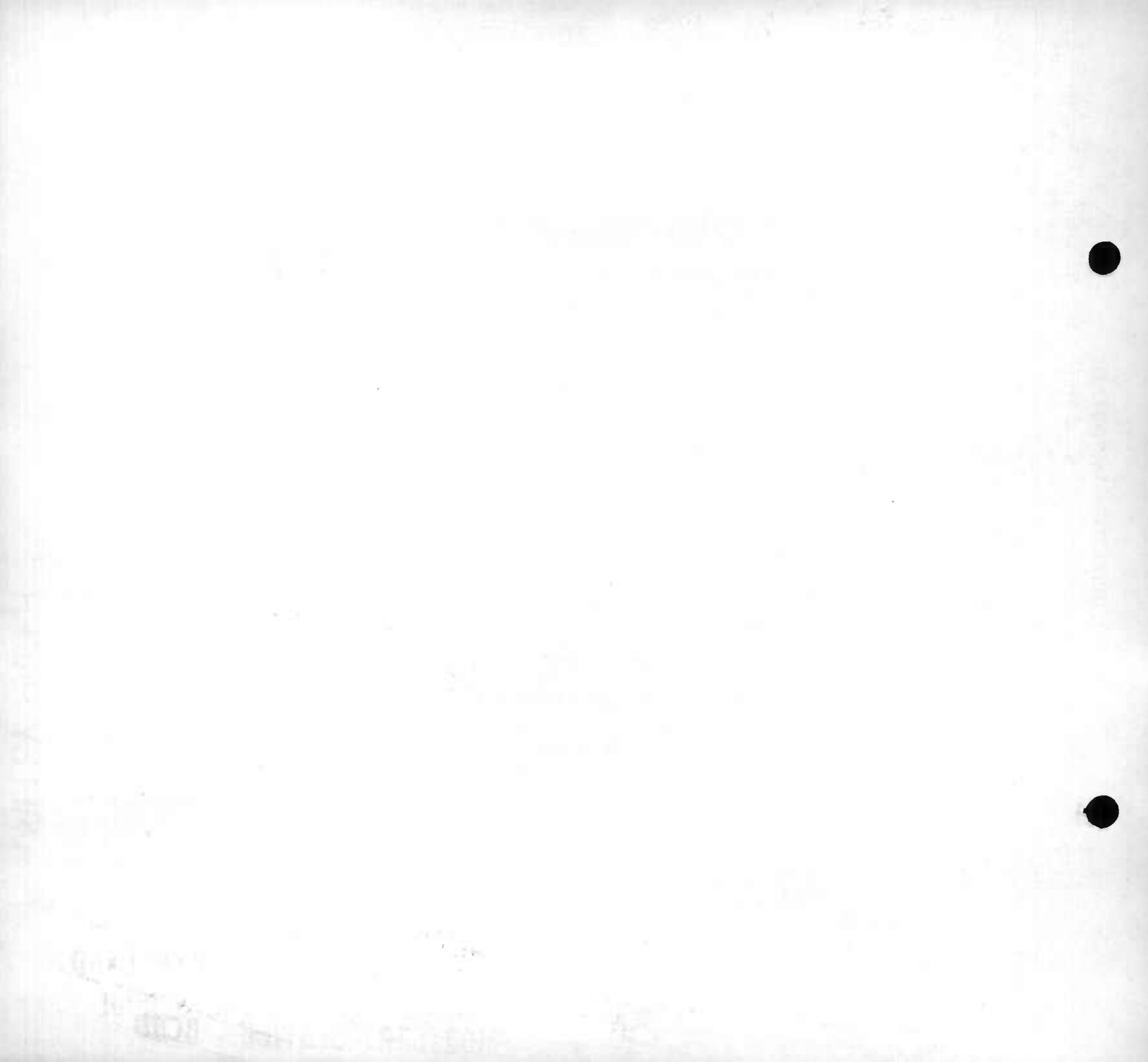


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. H-252		71 4289		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 71 4289	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) THOMAS HAWKINS			
2. DATE AND HOUR OF DEATH 4/26/71 - 1:10 P.M.				3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION 48 Md. GEN Hosp				(If not in hospital or institution, give street address or location)			
4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD. B. COUNTY 1401				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
D. STREET ADDRESS (If rural, give location) 1500 JOHN ST.				5. SEX M 6. RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)			
8. DATE OF BIRTH 7-30-86 9. AGE (In years last birthday) 84				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT				ADDRESS			
18. 486X1 CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Septic Shock Aspiration Pneumonia				(A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/21 19 71 to 4/26 19 71 , that (I) (we) last saw the deceased alive on 4/26 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Layman E. Elma, M.D. M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 4/26/71			
23C. PHYSICIAN'S NAME (Type) BAYANI B. ELMA, M.D. M.D.				23D. ADDRESS 827 LINDEN AVE BALTO MD.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4-30-71		24C. NAME OF CEMETERY or CREMATOR		24D. CITY, TOWNSHIP, COUNTY (State)	
25A. DATE REC'D BY HEALTH DEPT. MAY 4 1971		25B. NAME OF REGISTRAR John E. Talley, M.D.		25C. SUPERVISOR		25D. CITY, TOWNSHIP, COUNTY (State)	

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCMD



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>71 4290</u>	
BIRTH NO. <u>0-425 71 4290</u>		1. NAME OF DECEASED (Type or Print) <u>OLSEN, MR KORNELIUS</u>	
2. DATE AND HOUR OF DEATH <u>APRIL 30 1971</u>		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>CHURCH HOME AND HOSP BALTIMORE MD 21231</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>202</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2415 BROADWAY 21231</u>	
5. SEX <u>M</u>	6. RACE <u>W AMERICAN</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>07 22 92</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>78</u> II Under 1 Yr. Months Days III Under 24 Hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>NORWAY</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>CORNELIUS OLSEN SR</u>		14. MOTHER'S MAIDEN NAME <u>EMMA ?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS	
18. <u>185 X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) <u>SEVERE JAUNDICE</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>3 MONTHS</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>3 MONTHS</u> (B) <u>METASTASIS TO LIVER</u> DUE TO, OR AS A CONSEQUENCE OF: <u>3 MONTHS</u> (C) <u>CARCINOMA PROSTATE</u> DUE TO, OR AS A CONSEQUENCE OF: <u>3 MONTHS</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 MONTHS</u> <u>3 MONTHS</u> <u>3 MONTHS</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>HAEMATURIA</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 WEEK</u>	
19A. DATE OF OPERATION <u>0 -</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/29</u> 19 <u>71</u> to <u>4/30</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>4/29</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>A. Mehta</u> MD		23B. DATE SIGNED <u>4/30/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>A. MEHTA</u> MD		23D. ADDRESS <u>ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>5-4-71</u>	
24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 4 1971</u>		25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BOND</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 4291</u>	
P-652 <u>71-01554</u> <u>71</u> <u>4291</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Baby Girl Pringle</u>		2. DATE AND HOUR OF DEATH <u>4/20/71</u> <u>16:20</u> <u>A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>42 Sinai Hospital of Baltimore</u>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1504</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Female</u>		6. RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>4/20/71</u>		9. AGE (In years last birthday) <u>1</u> <u>52</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Phillip Pringle</u>	
14. MOTHER'S MAIDEN NAME <u>Dorothy Browner</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS			
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Prematurity</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Premature Rupture Membranes</u> (B) <u>Premature Rupture Membranes</u> DUE TO, OR AS A CONSEQUENCE OF:					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>4/20/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) <u>this hospital</u> attended the deceased from <u>4/20/71</u> 19 <u>71</u> to <u>4/20</u> 19 <u>71</u> that (2) <u>we</u> last saw the deceased alive on <u>4/20</u> 19 <u>71</u> and that (3) <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (1) <u>We</u> (did) (did not) view the body after death.					
23A. SIGNATURE <u>Louis L. Randall, M.D.</u>		23B. DATE SIGNED <u>4/21/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Louis L. Randall, M.D.</u>	
23D. ADDRESS		23E. ANATOMY BOARD OF MARYLAND			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>4-29-71</u>		24C. NAME OF CEMETERY or CREMATORY	
24D. LOCATION (City, town, or county)		24E. UNIVERSITY MEDICAL SCHOOL			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR SERVICE - BCMD	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 4292</u>	
K-523 <u>71 4292</u>		70-23484			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>KNIGHT BOY</u>		2. DATE AND HOUR OF DEATH <u>1-1-71</u> <u>9:10 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SINAI HOSPITAL OF BALTIMORE INC.</u> <u>42</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>CHASE ST.</u> # <u>021004</u>		
5. SEX <u>MALE</u> 6. RACE <u>NM</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>1-1-71</u> 9. AGE (in years last birthday) <u>-</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <u>SINAI HOSPITAL</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>JAMES KNIGHT</u>			14. MOTHER'S MAIDEN NAME <u>CLAUDETTE</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>SEPSIS</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>IMMATURITY</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>3 days</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>30 December</u> 19 <u>70</u> to <u>1 January</u> 19 <u>71</u> that (1) (we) lost saw the deceased alive on <u>1 January</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Anchalee Musikabhumma</u>		23B. DATE SIGNED <u>1-1-71</u>		23C. PHYSICIAN'S NAME (Type) <u>ANCHALEE MUSIKABHUMMA</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>4-29-71</u>		24C. NAME OF CEMETERY or CREMATOR <u>SINAI HOSPITAL</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 4 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.A.</u>		25C. NAME OF FUNERAL DIRECTOR <u>ANATOMY BOARD OF MARYLAND INC</u>	
25D. ADDRESS <u>UNIVERSITY MEDICAL SCHOOL</u> <u>MORTUARY SERVICE - BCDD</u>					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4293	
<div style="display: flex; justify-content: space-between;"> BIRTH NO. D-120 11-07050 71 4293 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED <small>(Type or Print)</small> BABY GIRL DAVIS			2. DATE AND HOUR OF DEATH 4-23-71 15:07 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY (202 N. Chesapeake)		
FULL NAME OF HOSPITAL OR INSTITUTION UNIVERSITY OF MARYLAND 38 HOSPITAL			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 1802
5. SEX F 6. RACE N			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-23-71
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —			10B. KIND OF BUSINESS OR INDUSTRY —		9. AGE (In years last birthday) 10 Months 10 Days 10 Hours 10 Min. 10
11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME LINDA DAVIS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT DR. AKESIDE, Univ. Hosp. MD. ADDRESS
18. CAUSE OF DEATH					
<div style="display: flex;"> <div style="flex: 1;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <small>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</small> ANTECEDENT CAUSES <small>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</small> </div> <div style="flex: 1;"> (A) IMMEDIATE CAUSE CONGENITAL MALFORMATION DUE TO, OR AS A CONSEQUENCE OF: ① ANENCEPHALY ② MENINGOCELE (B) DUE TO, OR AS A CONSEQUENCE OF: ENCEPHALOCOELE (C) </div> </div>					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-23 19 71 to 4-23 19 71 that (I) (we) last saw the deceased alive on 4-23 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE F. ADEMOLA AKESIDE MD, MPH				23B. DATE SIGNED 4-23-71	
23C. PHYSICIAN'S NAME (Type) F. ADEMOLA AKESIDE MD, MPH				23D. ADDRESS ANATOMY BOARD OF MARYLAND HSP.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4-30-71		24C. NAME OF CEMETERY OR CREMATORY	
24D. LOCATION (City, town, or county)		24E. LOCATION (State)		25A. DATE REC'D BY HEALTH DEPT. MAY 4 1971	
25B. NAME OF REGISTRAR JAMES E. ...		25C. FUNERAL DIRECTOR		25D. ADDRESS	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>71 4294</u>	
C-160 71 4294		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Cooper mv. Elmer A</u>		2. DATE AND HOUR OF DEATH <u>5.2.1971</u> <u>4.30 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>102</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>35 Church Home & Hospital Baltimore MD. 21231</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>137 S. Linwood Ave (24)</u>	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>03 16 99</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINE OPERATOR</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>CAN MFG.</u>	9. AGE (in years last birthday) <u>72</u>
11. BIRTHPLACE (State or foreign country) <u>Baltimore MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry B Cooper</u>		14. MOTHER'S MAIDEN NAME <u>Isabelle Crawford</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <u>Virginia Kross 137 S Linwood Ave 24</u>
18. <u>5-19-31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>chronic obstructive pulmonary disease</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>pneumonia; marked</u> DUE TO, OR AS A CONSEQUENCE OF: <u>coronary</u> (C) _____	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years.</u>			
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <u>04-17-1971</u> to <u>5.2.1971</u> that (H) (we) last saw the deceased alive on <u>5.2.1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Abdu Samad MD</u>			23B. DATE SIGNED <u>5.2.1971</u>
23C. PHYSICIAN'S NAME (Type) <u>ABDUS SAMAD MD</u>		23D. ADDRESS <u>Church Home & Hospital MD. Baltimore MD. 21231</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>MAY 71</u>	24C. NAME of CEMETERY or CREMATORY <u>BALTIMORE CEMETERY</u>	24D. LOCATION (City, town, or county) <u>BALTO. MD. 21208</u>
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 4 1971</u>	25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD</u>	25C. FUNERAL DIRECTOR ADDRESS <u>ULSICH FUNERAL HOME BALTO MD 21206</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-530 71 4295		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 4295	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		BONADIO MARIE HELEN		5/2/71 6:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE B. COUNTY			
S. BALTIMORE GEN'L HOSPITAL		Md. BALTIMORE 1200			
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
F		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Housewife				12/3/02	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday)	
Michael R.		? Anna		68	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		214-26-9834-A		HUSBAND. 521 Sylvain Dr Pasadena, Md 21222	
18. 23091		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		ASCVD.			
ANTECEDENT CAUSES		(B) BILAT. DIABETIC GANGRENE.			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) -			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If not, medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) last saw the deceased alive on 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
Aisha Simjee		5/2/71 6:40		AISHA SIMJEE	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		5/5/71		GLEN HAVEN MP	
25A. DATE REC'D BY HEALTH/DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAY 4 1971		J. E. Taylor, MD.		McCurly FH 737 Fatapoco ave.	
25D. LOCATION (City, town, or county) (State)		25E. ADDRESS			
GLEN BURNIE AACO M.					

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 4296
BIRTH NO. L-550		DATE AND HOUR OF DEATH April 30, 1971 4:00 A. M.		
1. NAME OF DECEASED (Type or Print) LOWMAN, HOWARD JOHN		2. DATE AND HOUR OF DEATH April 30, 1971 4:00 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY AA C. CITY OR TOWN Baltimore, D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER FOREST HAVEN NURSING HOME		
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5-5-1894	9. AGE (In years last birthday) 76
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bar tender		10B. KIND OF BUSINESS OR INDUSTRY 		11. BIRTHPLACE (State or foreign country) Brooklyn Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Thomas Lowman		
14. MOTHER'S MAIDEN NAME Charlotte Philps		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 5-27-18 to 5-17-19		
16. SOCIAL SECURITY NO. 213-01-5493		17. INFORMANT Records V. A. Hospital ADDRESS 3900 Loch Raven Blvd., Baltimore, Md.		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Atherosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years
19A. DATE OF OPERATION 		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) 		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Approx.) 		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that IX (this hospital) attended the deceased from March 23, 19 71 to April 30, 19 71 that X (we) last saw the deceased alive on April 30, 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (We) (did) (did not) view the body after death.				
23A. SIGNATURE Frederick Pearson MD				23B. DATE SIGNED 30 April '71
23C. PHYSICIAN'S NAME (Type) FREDERICK PEARSON, MD		23D. ADDRESS V. A. Hospital 3900 Loch Raven Blvd., Baltimore, Md. 21218		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5/3/71		24C. NAME of CEMETERY or CREMATORY CEDAR HILL
24D. LOCATION (City, town, or county) (State) Ritchie Hwy AA Co MD		25A. DATE REC'D BY HEALTH DEPT. MAY 4 1971		
25B. NAME OF REGISTRAR R. E. Fisher, M.D.		25C. FUNERAL DIRECTOR Mr. Cully F. H. 737 Satapue Ave.		

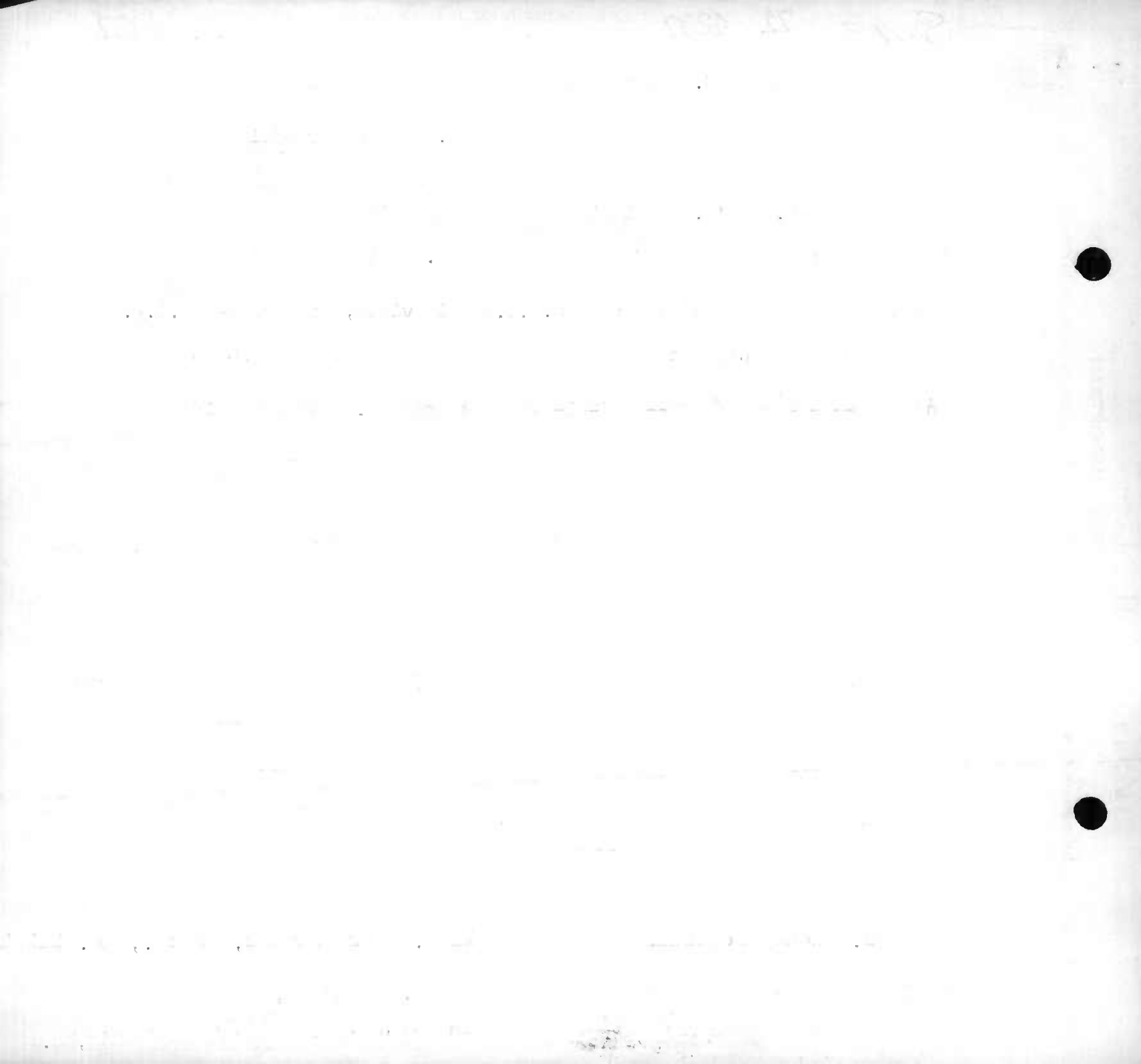
211 W 11th Ave. (25)

11/67 Adm.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> S-163 71 - 4297 </div>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X REG. NO. 71 4297	
BIRTH NO. S-163		1. NAME OF DECEASED (Type or Print) KENNETH C. SHEPPARD		2. DATE AND HOUR OF DEATH 30 April 1971	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 43 South Balto. Gen'l. Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY Anne Arundel 5200		C. CITY OR TOWN Linthicum	
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 205 Charles Road	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 Oct. 1907	9. AGE (In years last birthday) 63	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (ret)		10B. KIND OF BUSINESS OR INDUSTRY Union #96 (Wash. D.C.)		11. BIRTHPLACE (State or foreign country) Millville, New Jersey	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Herbert Sheppard		14. MOTHER'S MAIDEN NAME Bessie Dunham	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-01-0776		17. INFORMANT ADDRESS Catherine M. Sheppard (wife)	
<div style="display: flex;"> <div style="flex: 1;"> 18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="flex: 1;"> CAUSE OF DEATH (A) IMMEDIATE CAUSE Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF: (B) Atherosclerotic CVD. DUE TO, OR AS A CONSEQUENCE OF: (C) </div> <div style="flex: 0.5;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate 9 min. </div> </div>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examined) —			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR? —		22. I certify that (I) (this hospital) attended the deceased from 1-9- 19 71 to 2-12- 19 71 that (I) (we) last saw the deceased alive on 2-12- 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.			
23A. SIGNATURE [Signature]		23B. DATE SIGNED 5-3-71		23C. PHYSICIAN'S NAME (Type) Dr. Sidney Scherlis	
23D. ADDRESS 11 E. Chase Street, Balto., Md. 21202		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 3 May 1971		24C. NAME of CEMETERY or CREMATORY Meadowridge Memorial Pk.		24D. LOCATION (City, town, or county) (State) Elkridge, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 5 1971		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR ADDRESS Singleton Funeral Home/Glen Burnie, Md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT	
N-410		71 4298	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
NOLF, MACEL MAXINE		05 01 71 3:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
ST. AGNES HOSPITAL WILKENS & CATON AVENUES BALTIMORE, MARYLAND 21229		MD. BALTIMORE 5300	
5. SEX		6. RACE	
FEMALE		WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		04 03 26	
9. AGE (In years lost birthday)		10. AGE (In years lost birthday)	
45		45	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
WEST VIRGINIA		U.S.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
CHARLES EVANS		CATHERINE HAGER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
NO		233-38-6536	
17. INFORMANT		ADDRESS	
ST. AGNES HOSPITAL RECORDS			
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			
ANTECEDENT CAUSES			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from 04-23 1971 to 05-01 1971			
that (X) (we) last saw the deceased alive on 05-01 1971 and that in (XX) (our) opinion death occurred on the date			
and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED	
Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		MAY 1, 1971	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
DR. ADOLFO ALONSO		ST. AGNES HOSPITAL BALTIMORE MARYLAND	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
5/5/71			
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Memory Gardens		Madison West Virginia	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
MAY 5 1971		Robert J. Taylor, M.D.	
25C. FUNERAL DIRECTOR		ADDRESS	
Ambrose INC 1328 Sulphur Sp Rd.			

17

7 -

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

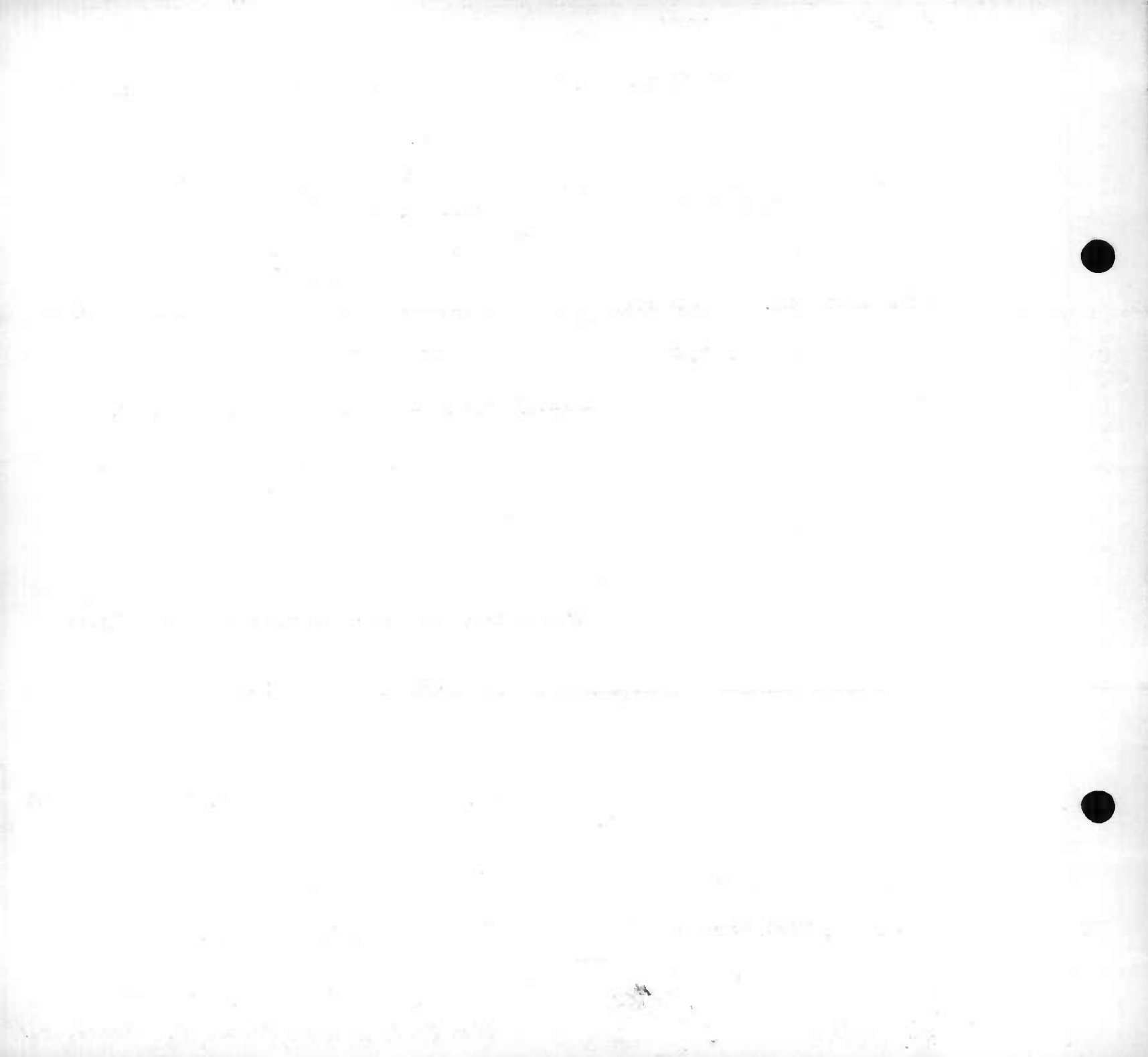
J-520		71 4299		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 4299	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) DESSIE S. JONES			
2. DATE AND HOUR OF DEATH 4-26-71				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 34 Box Secours Hosp.			
4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MD. B. COUNTY Lake Dr. Mrs. Home				C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 2401 Cutaw Place				5. SEX Female 6. RACE White			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 11-16-95 9. AGE (In years lost birthday) 75			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse				10B. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Joseph B Jones				14. MOTHER'S MAIDEN NAME Mirinda Hawkins			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 219-30-8193A			
17. INFORMANT Melvin C. Ingham				ADDRESS 8405 Bilboa Rd. Md 21133			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCUN + CVD + Chronic Renal disease = Azotemia				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12-25-68 to 4-26-71 that (I) (we) last saw the deceased alive on 4-26-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE W. Alburn				23B. DATE SIGNED 4-26-71			
23C. PHYSICIAN'S NAME (Type) Wm. L. F. DeBuena				23D. ADDRESS 7535 Pipers Park Sea Breeze Md 21061			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE April 30, 1971		24C. NAME OF CEMETERY OR CREMATORY St. Abraham's Cemetery		24D. LOCATION (City, town, or county) (State) Beckleysville, Balto Co, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 5 1971		25B. NAME OF REGISTRAR Robert E. Jones		25C. FUNERAL DIRECTOR James J. Hartman		ADDRESS New Freedom	

Adm. '65

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

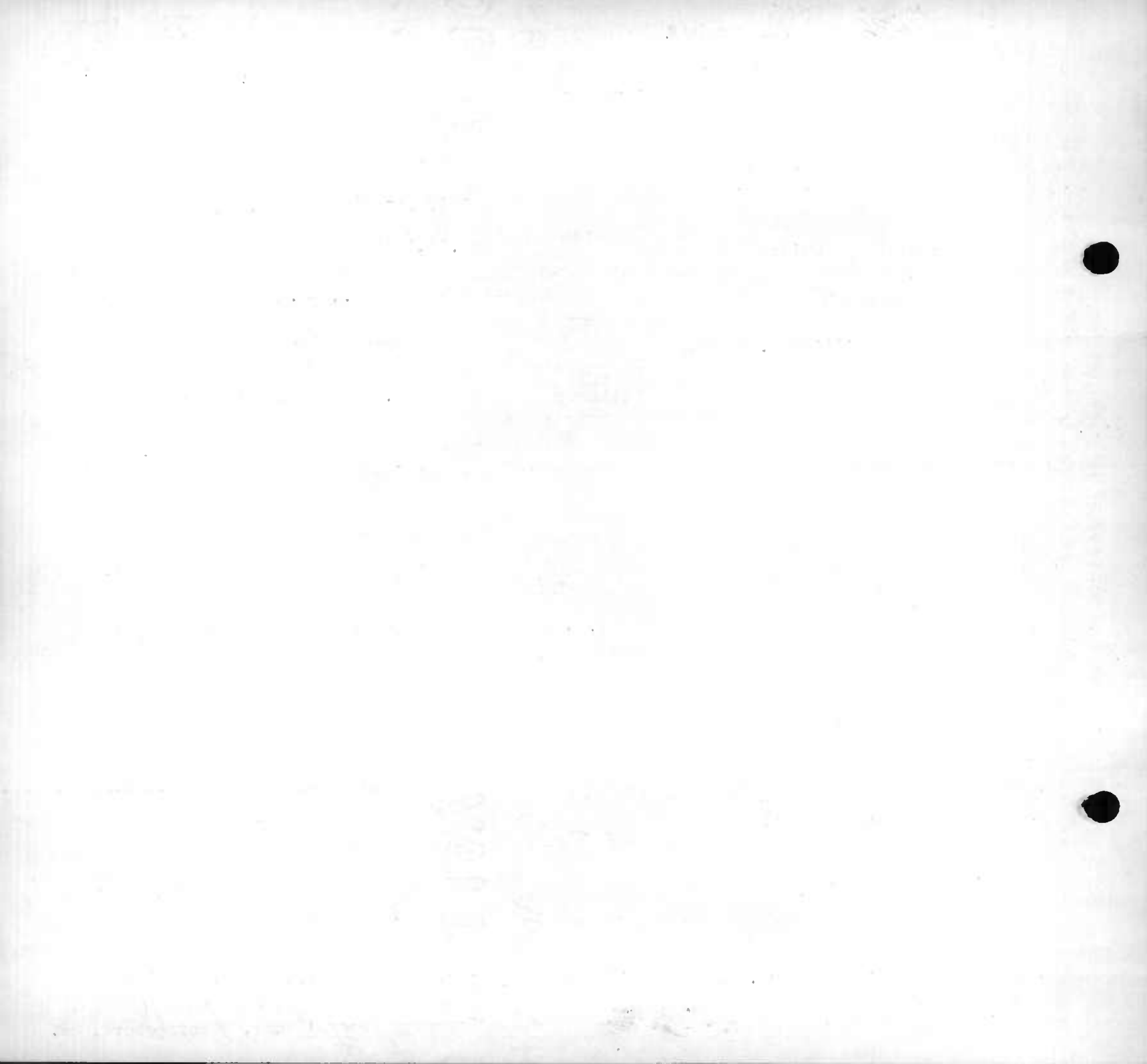
BIRTH NO. 71 4300		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 4300	
1. NAME OF DECEASED (Type or Print) Edward Clarence Hays			2. DATE AND HOUR OF DEATH April 29, 1971 9:50 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 2X US Public Health Service Hospital 3100 Wyman Parkway			A. STATE Md. B. COUNTY 1101		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 1211 St. Paul Street					
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/7/87	9. AGE (in years last birthday) 83	If Under 1 Yr. 1 Mo. 1 Day If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Relief Eng.		10B. KIND OF BUSINESS OR INDUSTRY Seafarer		11. BIRTHPLACE (State or foreign country) Florida	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME James W. Hays			14. MOTHER'S MAIDEN NAME Anna Davis		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 057-14-7938		
17. INFORMANT Records- US PHS Hospital, Balto, Md.			ADDRESS		
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Disseminated intravascular clotting (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II Arteriosclerotic cardiovascular disease			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) yes	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Apr. 29 19 71 to Apr. 29 19 71 that (I) (we) last saw the deceased alive on Apr. 29 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Samuel P. Ward, M.D.			23B. DATE SIGNED 4/29/71		
23C. PHYSICIAN'S NAME (Type) Samuel P. Ward, Surgeon (R)			23D. ADDRESS US PHS Hospital, Balto, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 4-30-71		24C. NAME OF CEMETERY OR CREMATORY Greenmount Crematory	
24D. LOCATION Baltimore, Md.		24E. LOCATION Baltimore, Md.		24F. LOCATION Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 5 1971		25B. NAME OF REGISTRAR Wm. Cook-Brooks, Towson, Inc.		25C. FUNERAL DIRECTOR Towson, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Badly burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

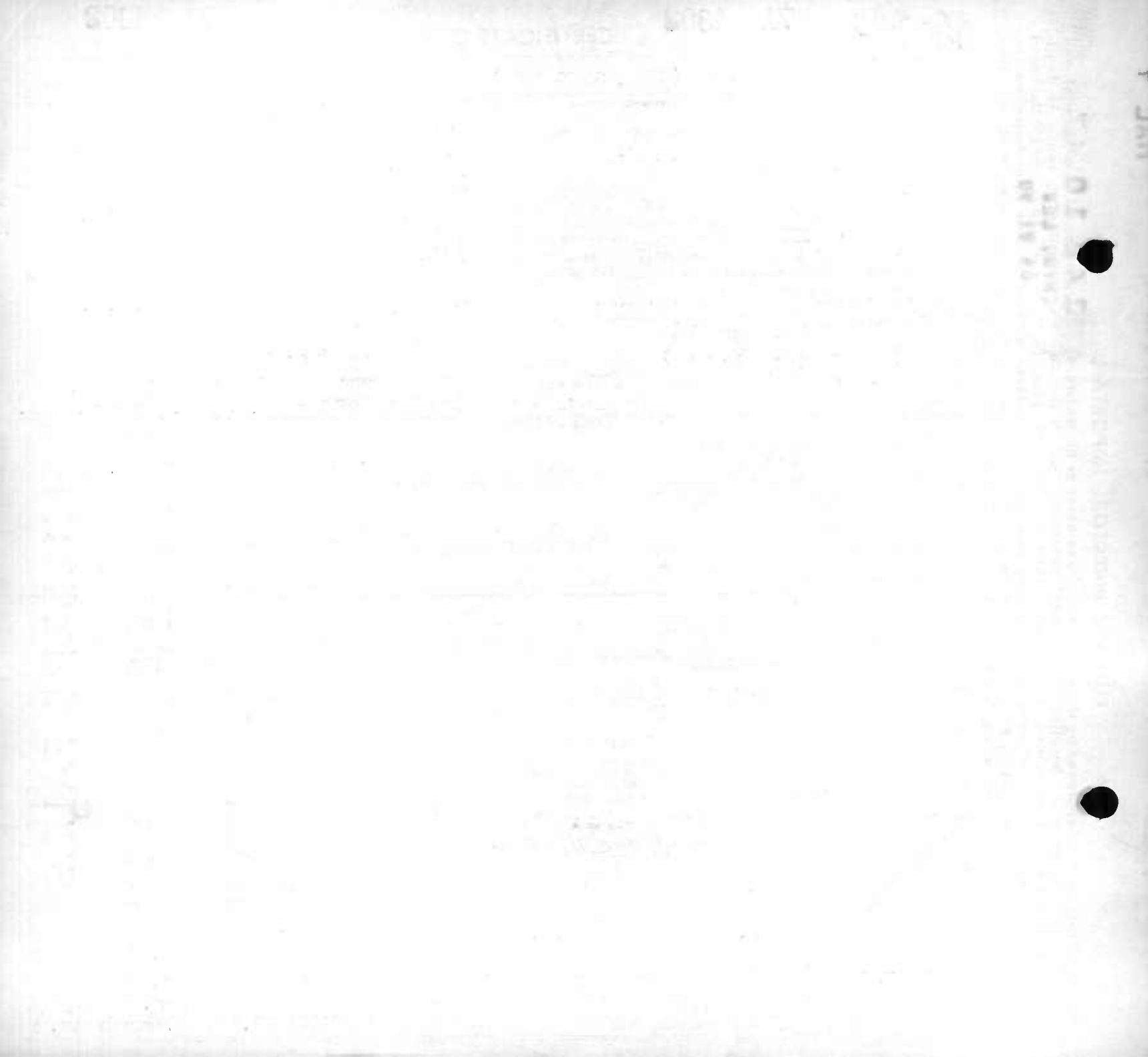
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
7-436		71 4301		71 4301	
1. NAME OF DECEASED (Type or Print) LILLIAN BEAN FELTER			2. DATE AND HOUR OF DEATH 4/26/71 1:13 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Gould Nursing Home 6116 Belair Road			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2731		
5. SEX Female			6. RACE White		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH Oct. 21, 1884		
9. AGE (In years lost birthday) 86			10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework			11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.		
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME William F. Reagan		
14. MOTHER'S MAIDEN NAME Frances Dunn			15. Was Deceased Ever in U. S. Armed Forces? (Yes, or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. Unknown			17. INFORMANT Cletus H. Felter, Baltimore, Maryland		
18. 486 X 1 + 250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused the death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Phlebotomy of suppurating (B) Peripheral Circulating Glycerin (C) Acute Pneumonia		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hours			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hours		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH year		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetes mellitus Chronic Phlebotomy of suppurating					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the deceased) attended the deceased from 6/19/66 to 4/26/71 that (I) (we) last saw the deceased alive on 4/24/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Albert B Bradley				23B. DATE SIGNED 4/26/71	
23C. PHYSICIAN'S NAME (Type) ALBERT B BRADLEY				23D. ADDRESS 4960 BELAIR ROAD BALTO. 21206 MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Apr. 29, 1971		24C. NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery	
24D. LOCATION (City, town, or county) Federsburg, Maryland		24E. DATE REC'D BY HEALTH DEPT. MAY 5 1971		24F. NAME OF REGISTRAR John Frampton Jr.	
24G. DATE REC'D BY HEALTH DEPT. MAY 5 1971		24H. NAME OF REGISTRAR John Frampton Jr.		24I. FUNERAL DIRECTOR Frampton Funeral Home, Federsburg, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH										REG. NO. 71 4302
BIRTH NO. C500 71 4302										
1. NAME OF DECEASED (Type or Print) Chin, Lew (CHIN, GING LEW)					2. DATE AND HOUR OF DEATH 5/4/71 1:00 A.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1802					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Johns Hopkins Hospital 33					C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
					E. STREET AND NUMBER 110 W. Saratoga Street 3rd Apt.					
5. SEX MALE M	6. RACE CHINESE Chin	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/21/90	9. AGE (In years last birthday) 80	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Owner	11. BIRTHPLACE (State or foreign country) Canton, China	12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Chin, Ang Yuen Sa. Ang X Yuen			14. MOTHER'S MAIDEN NAME Wong Shee							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 213-05-8674		17. INFORMANT son: 257 Richelieu St. Chin, Yee Tong - St. Jean, Quebec Can.				ADDRESS	
18. 5-22-01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Sepsis (B) Acute Pancreatitis DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 days 12 days										
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Renal failure										
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?						
22. I certify that (1) (this hospital) attended the deceased from May 1 19 71 to May 8 , 19 71 that (1) (we) last saw the deceased alive on May 3 , 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.										
23A. SIGNATURE David G. Ansel M.D.					23B. DATE SIGNED 4/4/71			23C. PHYSICIAN'S NAME (Type) David G. Ansel, M.D.		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL					24B. DATE May 7 1971		24C. NAME OF CEMETERY OR CREMATORY MOUNT ROYAL CEMETERY		24D. LOCATION (City, town, or county) (State) Montreal, Quebec, Canada	
25A. DATE REC'D BY HEALTH DEPT. MAY 5 1971			25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR STEWART & MOWEN CO. 108 W. North Av.					



R-262
BIRTH NO.

71 4303 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 4303

1. NAME OF DECEASED (Type or Print) CHARLES Joseph ROGERS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> May 1, 1971		Hour 7:45 A.M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 42 Sinai Hospital		3. DATE PRONOUNCED DEAD Month Day Year May 1, 1971		Hour 7:45 A.M.
6. SEX Male		7. RACE White		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH July 21, 1955		10. AGE (In years last birthday) 15		E. STREET AND NUMBER 6309 Pearce Ave.
11. BIRTH PLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF U.S.A.		13. FATHER'S NAME Milton Rogers
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		14B. KIND OF BUSINESS OR INDUSTRY School		15. MOTHER'S MAIDEN NAME Rae Kantor
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. no		18. INFORMANT Milton Rogers - 6309 Pearce Ave.
19. CAUSE OF DEATH E-95-BX DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Hypoxia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac arrest (B) DUE TO, OR AS A CONSEQUENCE OF: Hanging (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II 20A. DATE OF OPERATION 0 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) No				
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 6309 Pearce Ave. 2740
22D. TIME OF INJURY (APPROX.) 4-28-71		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Hanged self
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 5-1-71				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE May 2/71		24C. NAME OF CEMETERY OR CRYPTORY Ch. Burial Ground - Baltimore Md.
25A. DATE REC'D BY HEALTH DEPT. MAY 5 1971		25B. NAME OF REGISTRAR Robert J. Smith, M.D.		25C. FUNERAL DIRECTOR Sol Luriansky, D.D.S. 6010 Reid Rd.

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July 21/1952

Bartholomew, No 42A
Hobart

Milton Rogers
Roe Koster

no Milton Rogers - 6333

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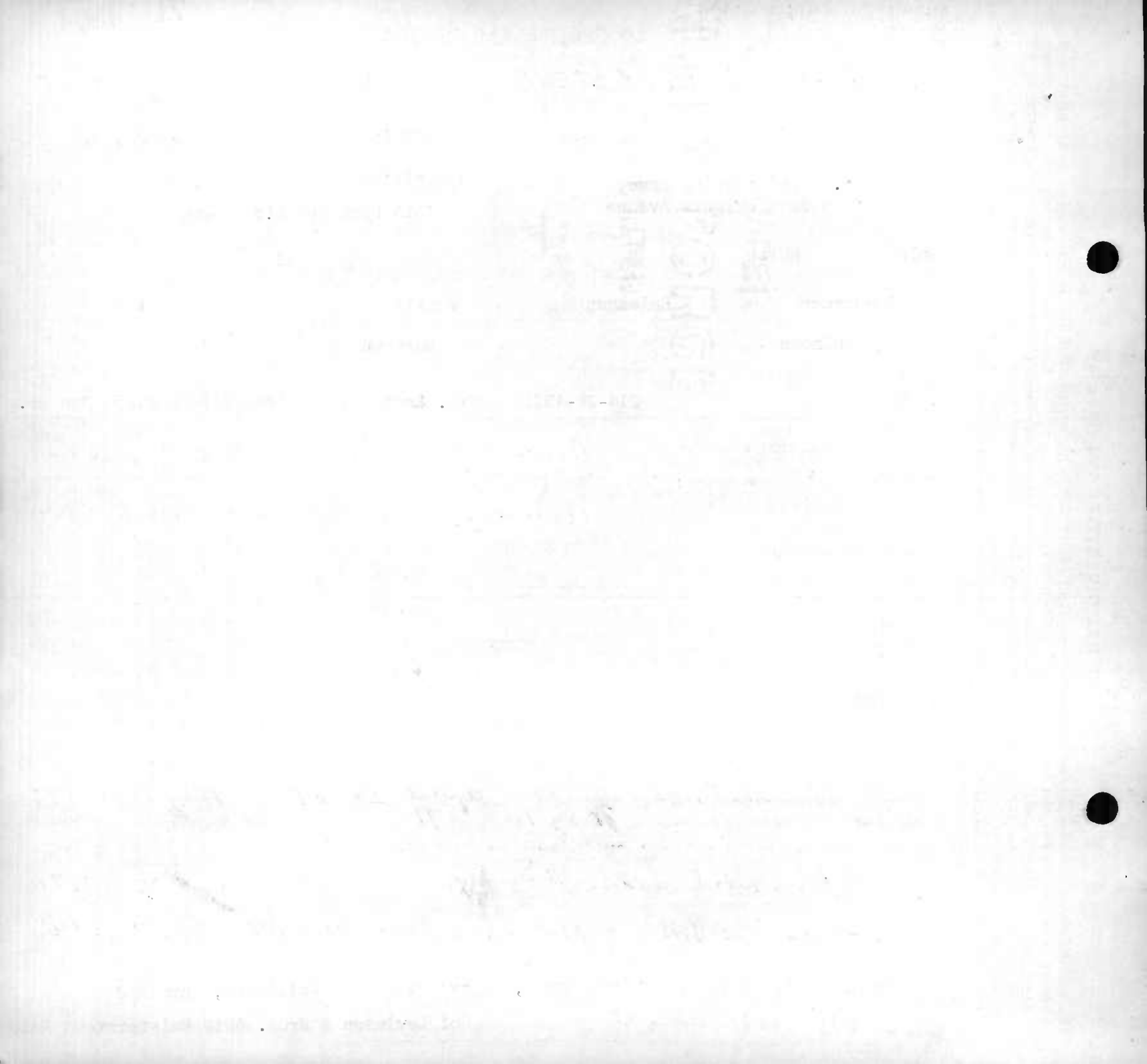
WALTER

Bartholomew, No 42A
Hobart

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4304		
BIRTH NO. S 4/6 71 4304		CERTIFICATE OF DEATH				
1. NAME OF DECEASED (Type or Print) HENRY SILBERSTEIN			2. DATE AND HOUR OF DEATH MAY 1, 1971 4³⁰ P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Mt. Sinai Nursing Home 4613 Park Heights Avenue			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2716 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4613 Park Heights Avenue			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 82		9. AGE (In years last birthday) 82	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance		10B. KIND OF BUSINESS OR INDUSTRY Salesman		11. BIRTHPLACE (State or foreign country) Russia		
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-20-4325A		17. INFORMANT ADDRESS Mrs. Saura Silberstein 2110 Western Run Dr.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.9 I Acute myocardial Infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic Heart Disease OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). none			CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 4 years			
19A. DATE OF OPERATION none			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED none		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) none		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? none		
22. I certify that (I) (this hospital) attended the deceased from April 29 1969 to May 1 1971 , that (I) (we) last saw the deceased alive on May 1 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE Manuel Levin M.D.					23B. DATE SIGNED May 1, 1971	
23C. PHYSICIAN'S NAME (Type) MANUEL LEVIN M.D.			23D. ADDRESS 6101 PARK HILLS AVE, BALTO 15 MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/2/1971		24C. NAME OF CEMETERY or CREMATORY Chizuk Amuno, Rogers Avenue		
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. MAY 5 1971 25B. NAME OF REGISTRAR R. E. Fisher, M.D. 25C. FUNERAL DIRECTOR Sol Levinson & Bros. 6010 Reisterstown Road				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> 11-455 71 4305 BALTIMORE CITY HEALTH DEPARTMENT </div> <div style="display: flex; justify-content: space-between;"> BIRTH NO. CERTIFICATE OF DEATH REG. NO. 71 4305 </div>			
1. NAME OF DECEASED (Type or Print) MILLMAN, ANNA		2. DATE AND HOUR OF DEATH 4/30/71 11:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSP. of BALTIMORE		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2929 OAKLEY AVENUE 2717	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 10, 1904
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME	9. AGE (In years last birthday) 66
11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ABRAHAM FINKELSTEIN		14. MOTHER'S MAIDEN NAME SARAH PESKOWITZ	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS MRS. MARY CARP, 2929 OAKLEY AVE. #21215
18. 410.9 18-250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD Arterio sclerosis Diabetes mellitus		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day years years years	
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 4/29 1971 to 4/30 1971 that (we) last saw the deceased alive on 4/30 1971 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.			
23A. SIGNATURE Alberto Barbedo, M.D.		23B. DATE SIGNED 4/30/71	
23C. PHYSICIAN'S NAME (Type) ALBERTO BARBEDO, M.D.		23D. ADDRESS Sinai Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 5-2-71	24C. NAME OF CEMETERY OR CREMATORY BETH JACOB ANSHE VESHEAR	24D. LOCATION (City, town, or county) (State) ROSEDALE, MARYLAND
25A. DATE REC'D BY HEALTH DEPT. MAY 5 1971		25B. NAME OF REGISTRAR Robert Taylor, M.D.	25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD

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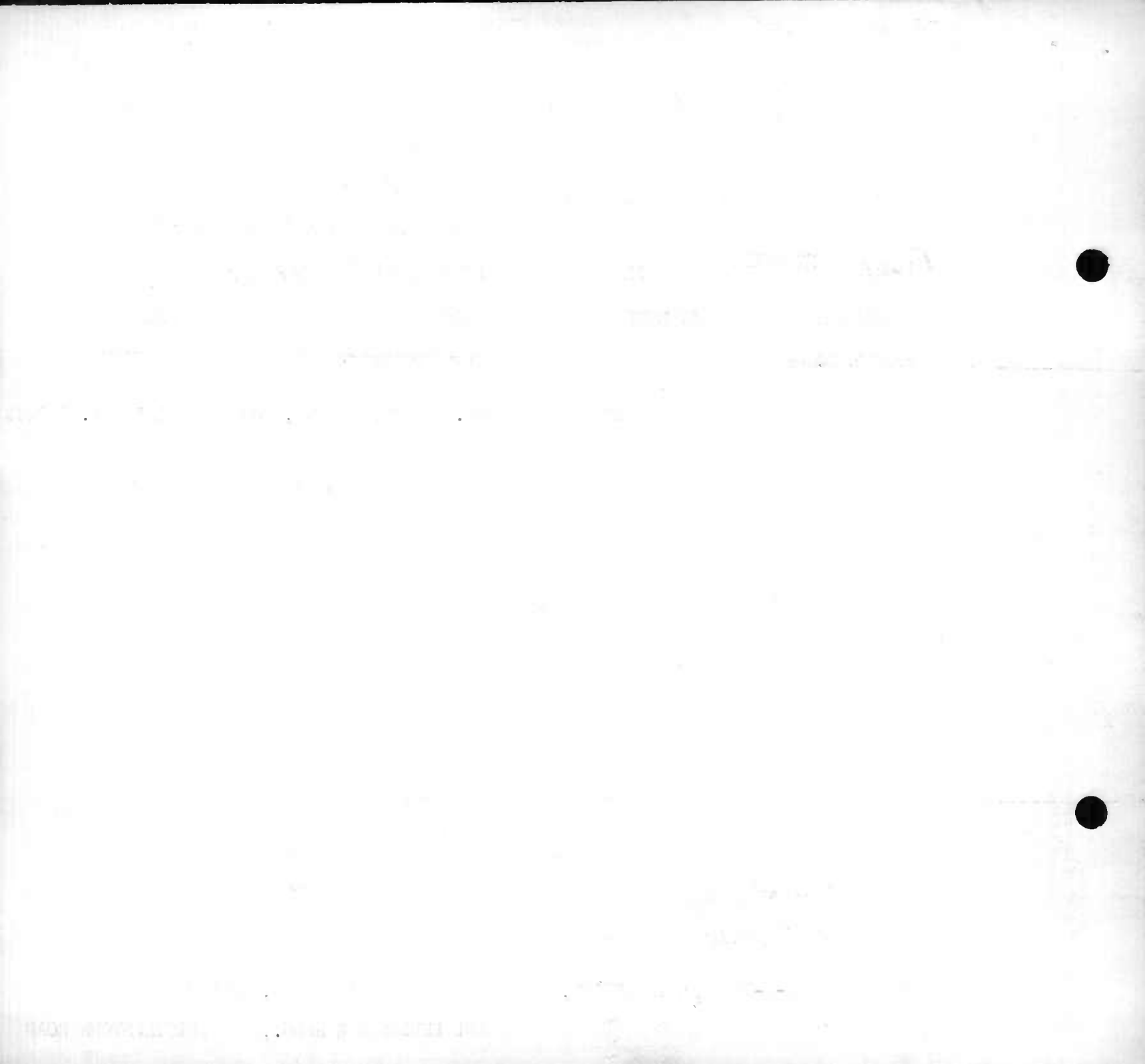
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4306	
2-250 71 4306				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) ZACKON, GOLDIE		2. DATE AND HOUR OF DEATH 30th APRIL 1971 9.30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL OF BALTIMORE INC.			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTO.		
			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 6823 HUNTINGTON DRIVE #21207		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-10-1895	9. AGE (In years last birthday) 76
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) RUSSIA	
13. FATHER'S NAME SAMUEL ZENUK		14. MOTHER'S MAIDEN NAME TOBA PLOTNICK			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT ADDRESS MRS. LEONA ADLEBERG, 3309 GREENVALE RD. #21208	
18. 174X+1-250.9 CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of Left breast	
				(B) DUE TO, OR AS A CONSEQUENCE OF:	
				(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetes mellitus, Decubitus ulcers					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11th April 1971 to 30th April 1971 that (I) (we) last saw the deceased alive on 30th April 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Prasad MBBS				23B. DATE SIGNED 30th April 1971	
23C. PHYSICIAN'S NAME (Type) P. PRASAD MBBS				23D. ADDRESS Sinai Hospital, Balto., Md 21215.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5-2-71		24C. NAME OF CEMETERY or CREMATORY BETH TFILOH,	
24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND					
25A. DATE REC'D BY HEALTH DEPT. MAY 5 1971		25B. NAME OF REGISTRAR J. C. [unclear]		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-656		71 4307		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 4307	
1. NAME OF DECEASED (Type or Print) <i>Anna Cherner</i>				2. DATE AND HOUR OF DEATH <i>May 1, 1971 12:40 P.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Jewish Convalescent Home</i>				A. STATE <i>Maryland</i>		B. COUNTY <i>2740</i>	
<i>4601 Fall Mall Rd.</i>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>3103 Bancroft Rd.</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 1878</i>	9. AGE (In years last birthday) <i>92</i>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		11. BIRTH PLACE (State or foreign country) <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Raphael Kaprow</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>No.</i>		17. INFORMANT <i>Louis Cherner</i>			
				ADDRESS <i>3103 Bancroft Rd.</i>			
18. <i>412131</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <i>ARTERIOSCLEROTIC HEART Disease.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 yr.</i>	
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medico examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>April 26</i> 19 <i>71</i> to <i>May 1</i> 19 <i>71</i> , that (I) (we) last saw the deceased alive on <i>April 30</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death.							
23A. SIGNATURE <i>Albert HimelefARB</i>				23B. DATE SIGNED <i>MAY 2/71</i>		23C. PHYSICIAN'S NAME (Type) <i>ALBERT HIMELEFARB</i>	
		23D. ADDRESS <i>222 W. COLD SPRING LANE</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Remove - Burial 5/2/71 Holy Trinity Church</i>		24B. DATE <i>5/2/71</i>		24C. NAME OF CEMETERY <i>Buffalo, N.Y.</i>		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 5 1971</i>		25B. NAME OF REGISTRAR <i>John E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>John E. Taylor, M.D.</i>		25D. ADDRESS <i>6010 Baltimore Rd.</i>	

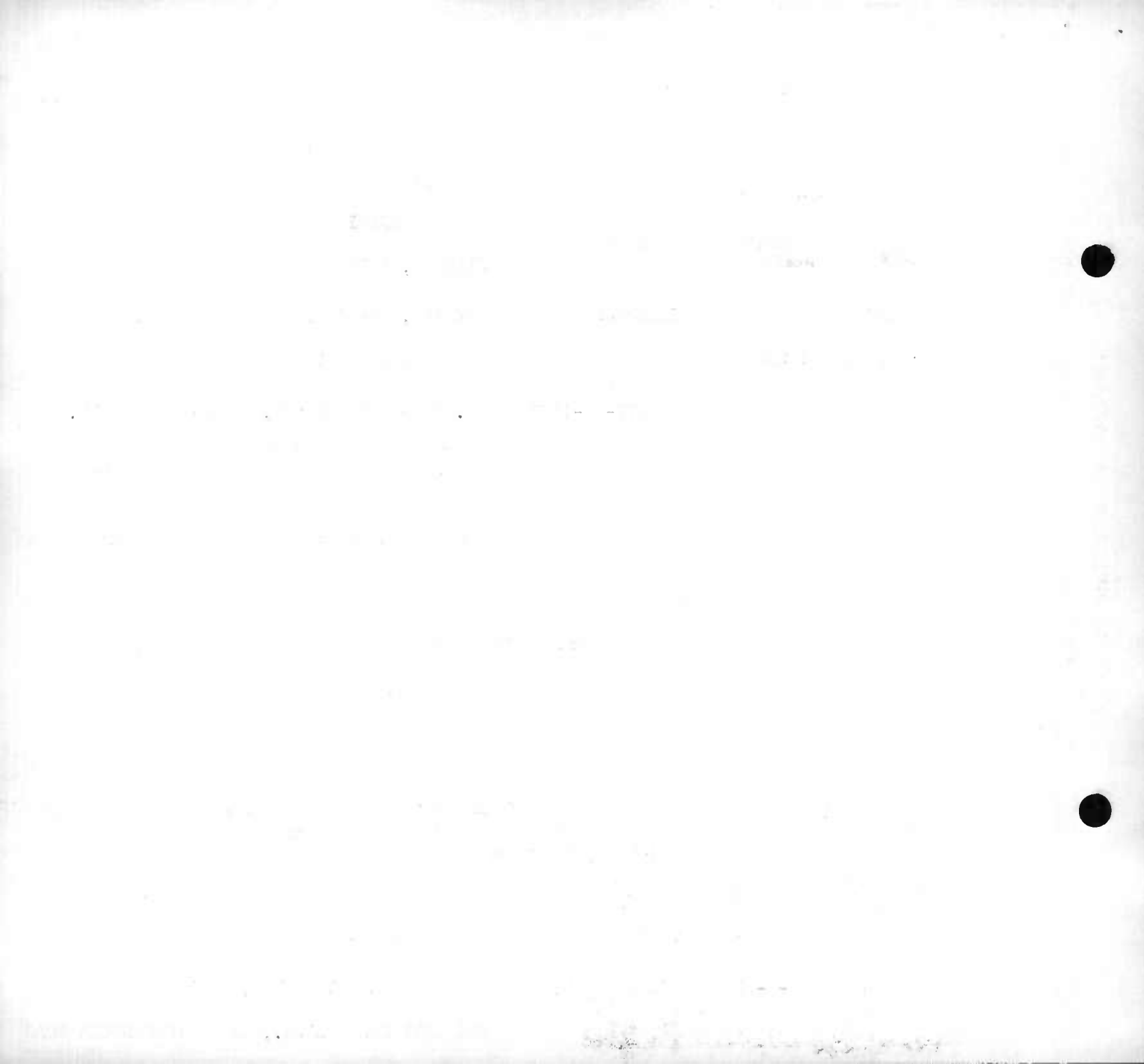
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4308	
<div style="display: flex; justify-content: space-between;"> G-514 71 4308 </div> <div style="text-align: center; font-weight: bold; font-size: 1.2em;">CERTIFICATE OF DEATH</div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		<i>Rose Samkel</i>		<i>May 1, 1971 4:15 P.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE		
			B. COUNTY		
<i>90 Belvedere Nursing Home</i>			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			<i>Baltimore</i>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			<i>5355 List Ave</i>		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
<i>Female</i>	<i>White</i>	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<i>April 30, 1897</i>	<i>74</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
<i>Housewife</i>		<i>Home</i>		<i>U.S.A.</i>	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
<i>Unknown</i>			<i>Unknown</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
		<i>218-32-22108</i>		<i>Frank Samkel - 1600 Carlton Ave</i>	
				<i>21226</i>	
18. <i>250.91</i> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p style="text-align: center;">(A) IMMEDIATE CAUSE</p> <p style="text-align: center;"><i>Cardio Respiratory Failure</i></p> <p style="text-align: center;">DUE TO, OR AS A CONSEQUENCE OF:</p> <p style="text-align: center;"><i>Arteriosclerotic CVD</i></p> </div> <div style="width: 45%;"> <p style="text-align: center;">(B) <i>Parkinson's Disease</i></p> <p style="text-align: center;">DUE TO, OR AS A CONSEQUENCE OF:</p> <p style="text-align: center;"><i>Diabetes Mellitus</i></p> </div> </div>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
<i>0</i>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from <i>April 29</i> 19 <i>71</i> to <i>May 1</i> 19 <i>71</i> , that (I) (we) last saw the deceased alive on <i>May 1</i> 19 <i>71</i> and that in (my) (an) opinion death occurred on the date and hour and from the causes stated above. (I) (Yes) (<i>No</i>) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<i>Willard Applefeld</i>					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
<i>WILLARD APPLEFELD</i>				<i>6615 Reisterstown Rd.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
<i>Burial</i>		<i>5/3/71</i>		<i>Bobroisker</i>	
				<i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
<i>MAY 5 1971</i>		<i>Robert C. Taylor</i>		<i>6010 Ring Rd.</i>	
				<i>Bob Taylor & Son Inc.</i>	

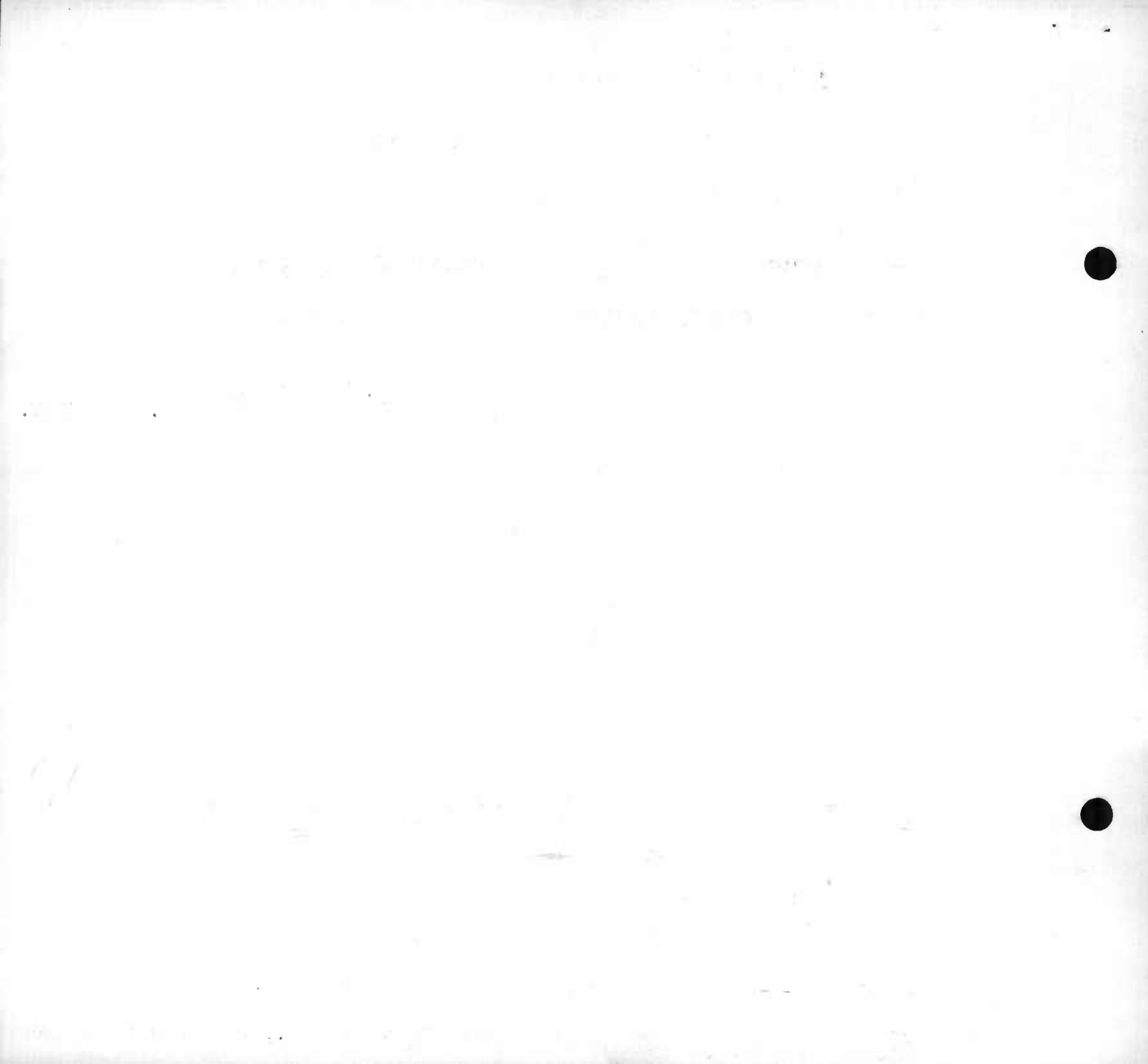
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>W-435</u> <u>71</u> <u>4309</u>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH <u>X</u>		REG. NO. <u>71</u> <u>4309</u>	
1. NAME OF DECEASED (Type or Print) <u>Barney Waldman</u>			2. DATE AND HOUR OF DEATH <u>5-1-1971</u> <u>7:25 P. M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>91</u> <u>Levindale</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> <u>Baltimore</u> C. CITY OR TOWN <u>BALTIMORE</u> E. STREET AND NUMBER <u>3223 XXXX MIDFIELD ROAD</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <u>male</u>	6. RACE <u>WHITE</u> <u>human</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 22, 1911</u>	9. AGE (In years last birthday) <u>59</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BROKER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>INSURANCE</u>	11. BIRTHPLACE (State or foreign country) <u>NEWARK, NEW JERSEY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>BENJAMIN WALDMAN</u>			14. MOTHER'S MAIDEN NAME <u>CECELIA ?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>577-03-4177</u>	17. INFORMANT ADDRESS <u>MRS. JEANETTE WALDMAN, 3223 MIDFIELD RD. #8</u>		
18. <u>441.21</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Ruptured Abdominal Aortic Aneurysm</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerosis</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Pre senile dementia</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>years</u> <u>years</u>		
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>yes</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) 1 Month (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (it) (this hospital) attended the deceased from <u>2-12-1968</u> 19 <u>5-1</u> to <u>5-1</u> 19 <u>71</u> that (it) (we) last saw the deceased alive on <u>5-1</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.)					
23A. SIGNATURE <u>Theodore R. Bieff</u> MD DEGREE			Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>5-2-1971</u>
23C. PHYSICIAN'S NAME (Type) <u>Theodore R. Bieff, MD</u>			23D. ADDRESS <u>Levindale</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>5-3-71</u>	24C. NAME of CEMETERY or CREMATORY <u>BALTIMORE HEBREW</u>	24D. LOCATION (City, town, or county) (State) <u>REISTERSTOWN, MARYLAND</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 5 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Gable, R.D.</u>	25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

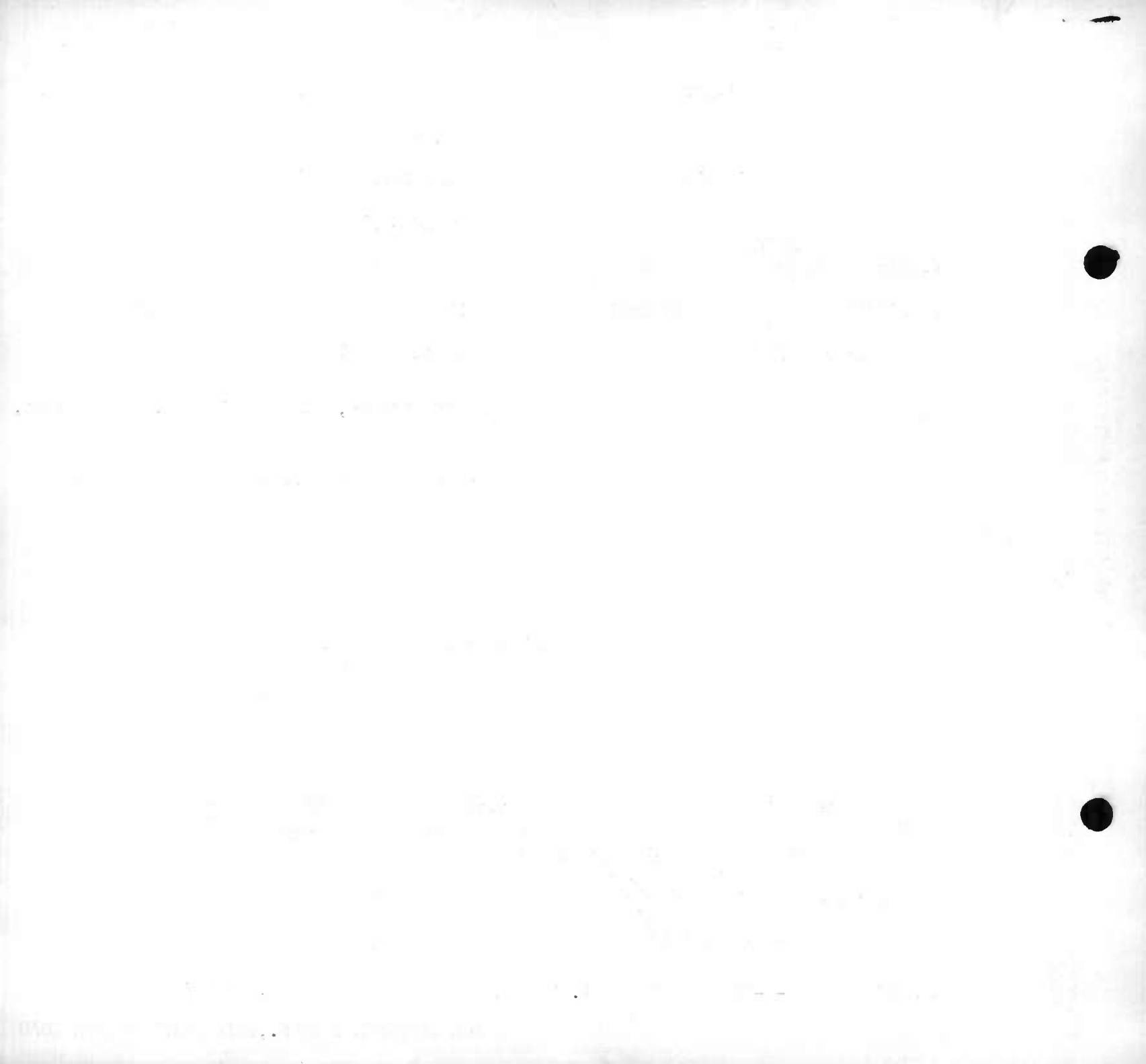
VS 150-REV. 1/1/68



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

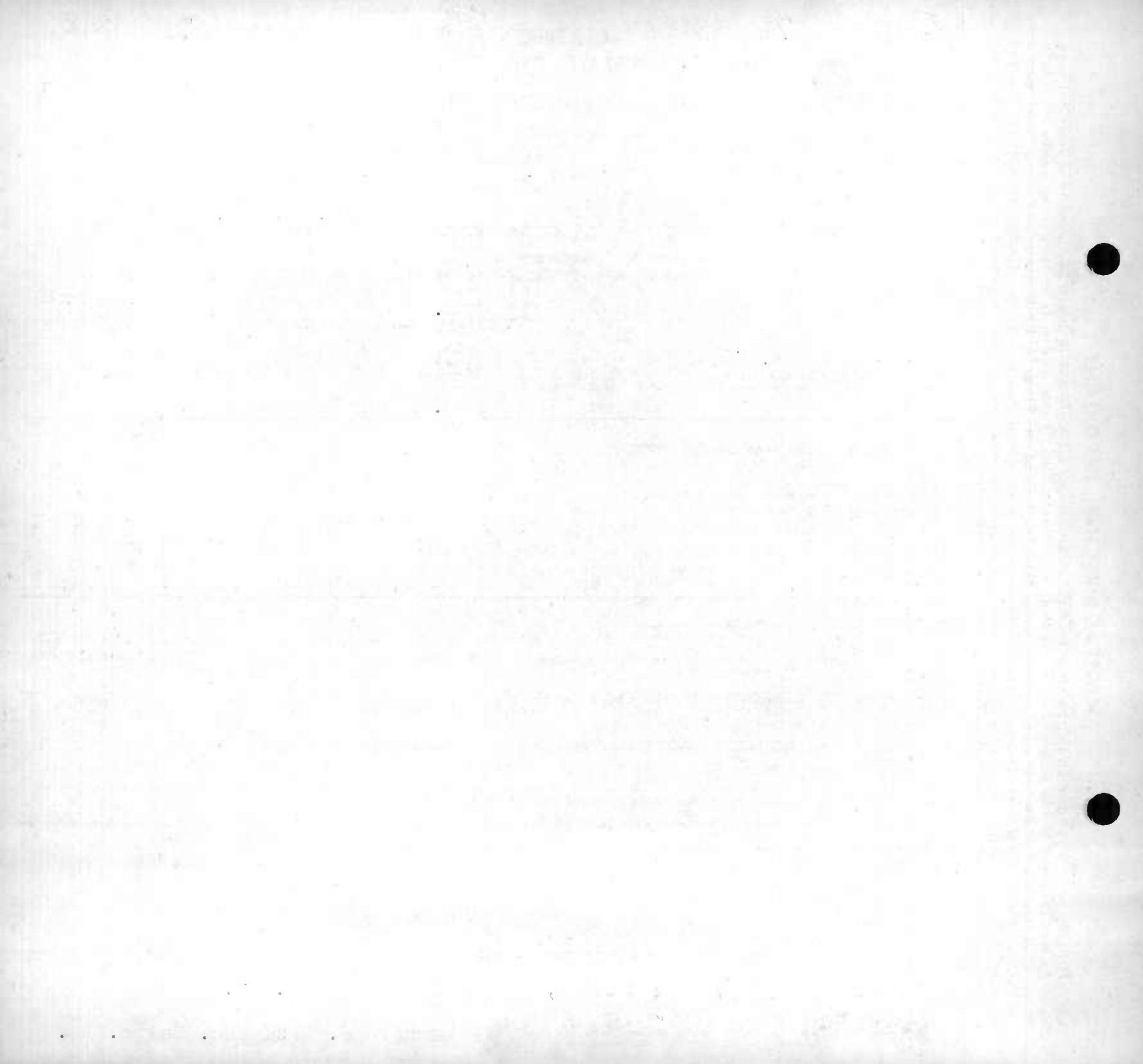
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 4311</u>	
BIRTH NO. <u>S-526</u>		71 4311		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Ray Singer</u>			2. DATE AND HOUR OF DEATH <u>5-2-1971</u> <u>8:30 A.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>91</u> Levindale			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> <u>Baltimore</u> B. COUNTY <u>5300</u>		
5. SEX <u>female</u>			6. RACE <u>WHITE</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>85</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		
11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>NORMAN LEON FRISHMAN</u>			14. MOTHER'S MAIDEN NAME <u>SARAH ?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>NO</u>		
17. INFORMANT <u>MAURICE SINGER, 9925 HOYT CIRCLE, RANDALLSTOWN,</u>			ADDRESS		
18. <u>4-12-31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF: <u>years</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>cholelithiasis, depression</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? <u>Yes</u> (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(he)</u> (this hospital) attended the deceased from <u>5-22</u> <u>19 56</u> to <u>5-2</u> <u>19 71</u> that <u>(he)</u> (we) last saw the deceased alive on <u>5-2</u> <u>19 71</u> and that <u>(in my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(We)</u> (I) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Theodore R. Beiff</u> MD			23B. DATE SIGNED <u>5-2-1971</u>		
23C. PHYSICIAN'S NAME (Type) <u>Theodore R. Beiff, MD</u>			23D. ADDRESS <u>Levindale</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>5-3-71</u>		24C. NAME of CEMETERY or CREMATORY <u>HEBREW MT. CARMEL</u>	
24D. LOCATION <u>BALTIMORE, MARYLAND</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 8 1971</u>		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

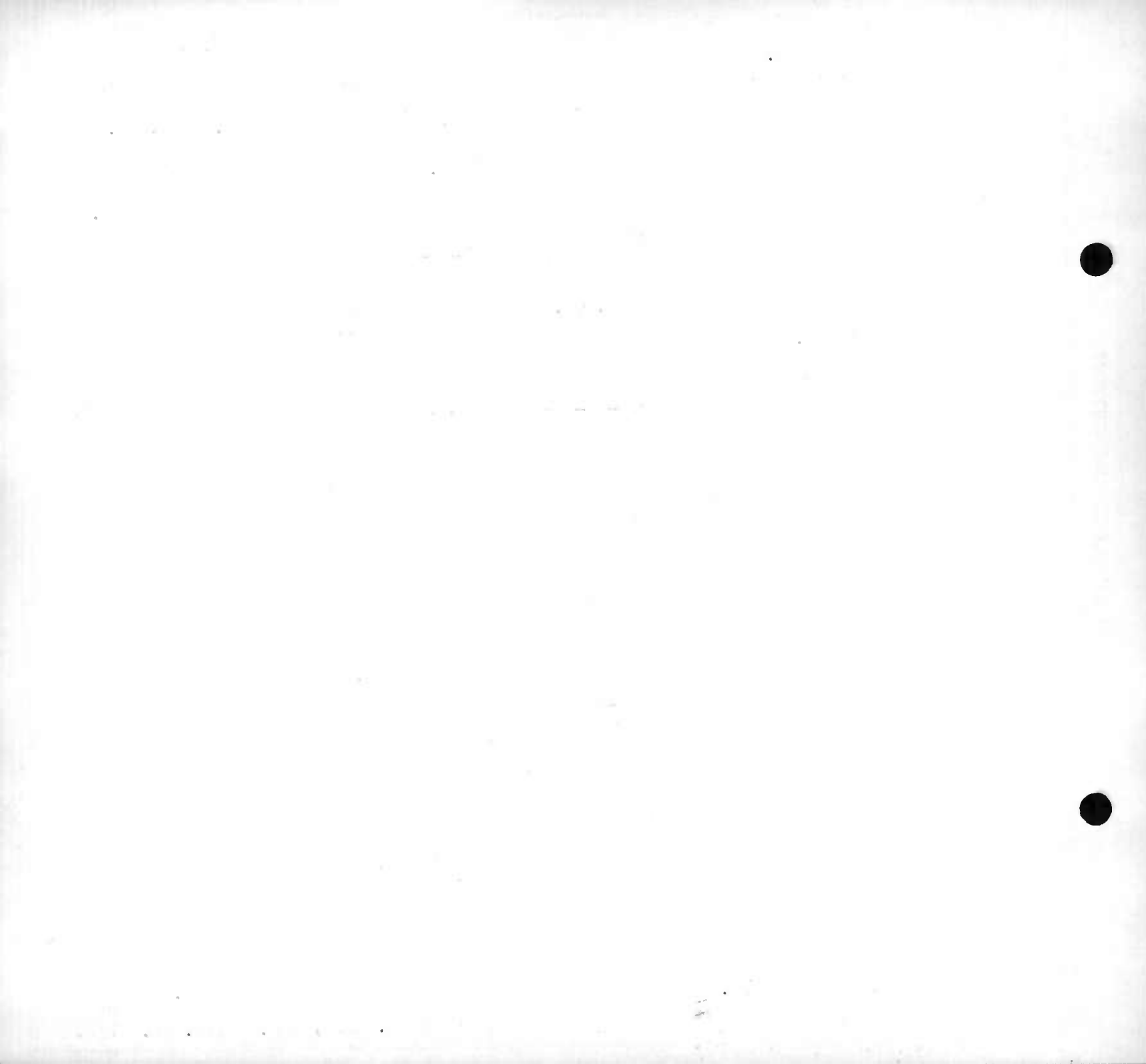
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 4312</u>	
T-620 <u>71 4312</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Ellen C. Towers</u>		2. DATE AND HOUR OF DEATH <u>4-29-71</u> <u>6</u> <u>PM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>45</u> <u>The Good Samaritan Hosp.</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Balto.</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
		E. STREET AND NUMBER <u>4238 Cardwell Ave.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-25-96</u>	9. AGE (In years last birthday) <u>74</u> yr.	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>RUDOLPH KLITCH</u>		14. MOTHER'S MAIDEN NAME <u>MARY ELLEN E. Fanning</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>210408862</u>		17. INFORMANT <u>Mrs. Ellen Shockley</u> ADDRESS <u>same</u>	
18. <u>410.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>respiratory arrest</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u>	
		(B) <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>1 month</u>	
		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>William A. Carter MD</u>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>WILLIAM A. CARTER</u>	
		23D. ADDRESS <u>GOOD SAMARITAN</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>5/3/71</u>	24C. NAME OF CEMETERY or CREMATORY <u>Baltimore, National</u>	24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 5 1971</u>	25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>	25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto. Md.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>71 4313</u>	
BIRTH NO. <u>K-510</u>		71 4313					
1. NAME OF DECEASED (Type or Print) <u>Albert Knop</u>				2. DATE AND HOUR OF DEATH <u>4-30-71</u> <u>12:45</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>B. COUNTY</u> <u>3107 Chesterfield Ave. Balt. Md.</u> <u>2633</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Mercy Hospital</u>				C. CITY OR TOWN <u>Balt.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>3107 Chesterfield Ave.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-26-1900</u>	9. AOE (In years lost birthday) <u>71</u>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Gas & Elec. Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Albert A. Knop</u>				14. MOTHER'S MAIDEN NAME <u>Mary Drull</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>212-05-4081</u>		17. INFORMANT <u>Mrs. Sarah Knop</u>		
					ADDRESS <u>(Same)</u>		
18. <u>410.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Acute myocardial infarction & cardiogenic shock</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Aseptic</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>CVA</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>4/29/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Excision of Pacemaker</u>		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>4/29/1971</u> to <u>4/30/1971</u> that (I) (we) last saw the deceased alive on <u>12:45 am 4/30/1971</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Pratima Bose M.D.</u>				23B. DATE SIGNED <u>4/30/71</u>		23C. PHYSICIAN'S NAME (Type) <u>PRATIMA BOSE M.D.</u>	
				23D. ADDRESS <u>Mercy Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/3/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 5 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-563 71 4314		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 4314	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		John Cammarata		April 29, 1971	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		B. COUNTY	
00 North 625 Duncan St		Maryland		703	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Retired Grocer				May 16, 1895	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (in years last birthday)	
Vincent Cammarata		Clementina Trionfo		75	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country)	
No		217-32-7825		Italy	
18. CAUSE OF DEATH		17. INFORMANT		12. CITIZEN OF WHAT COUNTRY?	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		Mrs Alfina Cammarata		U.S.A.	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		Same			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Myocardial Infarction	
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		cva			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 11 3 19 58 to JAN 10 19 71 and that (I) (we) last saw the deceased alive on Jan 10 19 71 and that (I) (we) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Sebastian Russo		4/29/71			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Sebastian Russo M.D.		5017 Harford Rd Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		5/3/71		Most Holy Redeemer Cem. Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAY 5 1971		Leonard J Ruck Inc.		Baltimore, Md	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4315	
<div style="display: flex; justify-content: space-between;"> H-532 71 4315 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print) George Henry Hentschel		2. DATE AND HOUR OF DEATH 5-1-71 3 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 00 5912 Arabia Avenue			A. STATE Md. B. COUNTY 2744		
C. CITY OR TOWN Baltimore			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 5912 Arabia Avenue					
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 14, 1926	9. AGE (In years last birthday) 44	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cost Analysis		10B. KIND OF BUSINESS OR INDUSTRY General Motors		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Paul J. Hentschel			
14. MOTHER'S MAIDEN NAME Christine E. Rupp		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes <input type="checkbox"/> W W 2 <input type="checkbox"/>			
16. SOCIAL SECURITY NO. 217-20-0782		17. INFORMANT ADDRESS Mrs. Jean M. Hentschel (Same)			
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE Cancer of lung DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 year					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 1621		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from April 1960 to May 1 1971 , that (I) (we) last saw the deceased alive on April 24 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Donald Jandorf				23B. DATE SIGNED 5-1-71	
23C. PHYSICIAN'S NAME (Type) Donald Jandorf MD				23D. ADDRESS 7403 Harford Rd.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/4/71		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. MAY 5 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc. Balto. Md. 21214	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

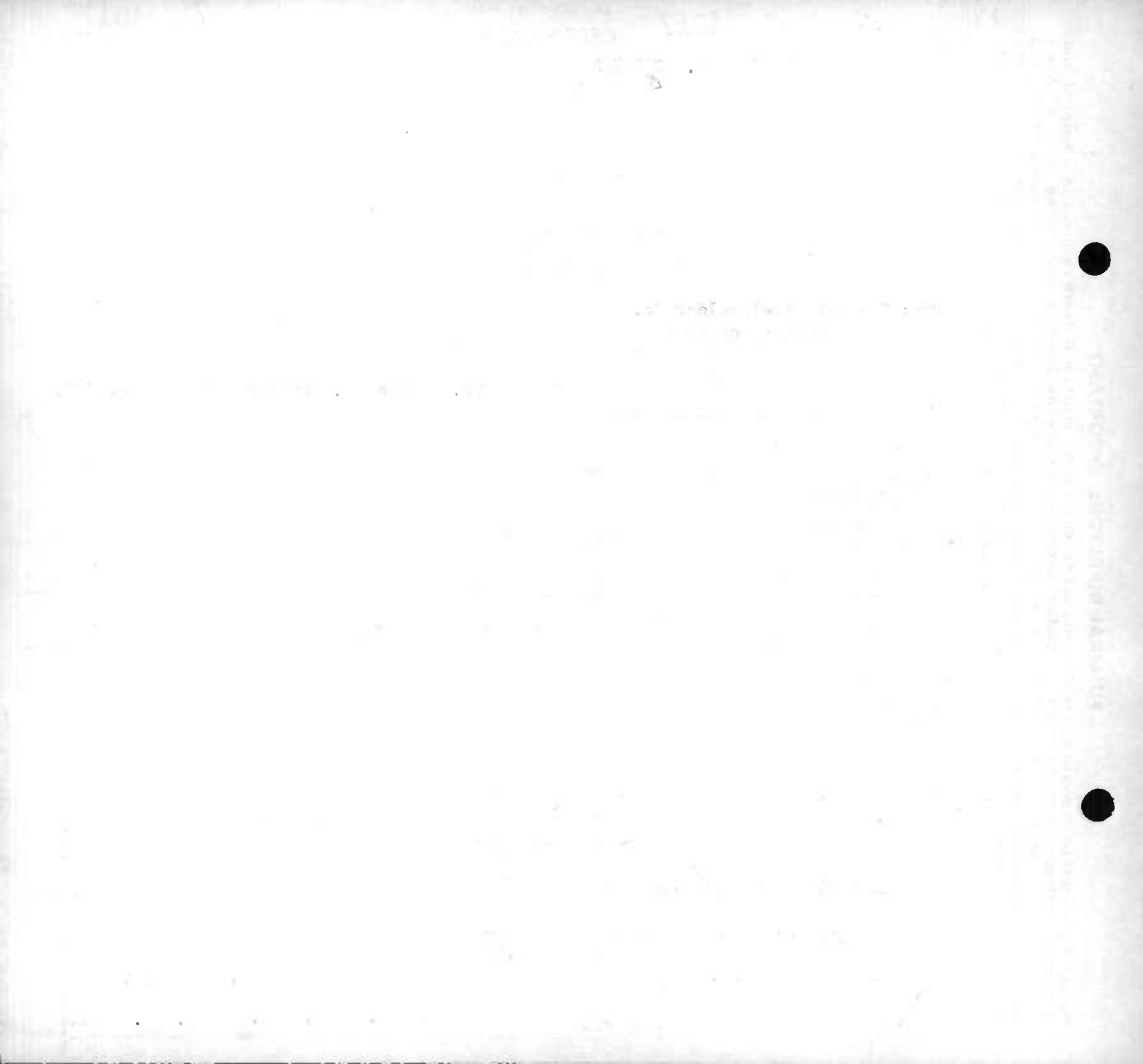
1. NAME OF DECEASED (Type or Print) JOSEPH M. CARNEY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 (Vacant lot = 5100 blk Harford Road)		3. DATE PRONOUNCED DEAD Month Day Year Hour May 1, 1971 10:00 A.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Aug. 19, 1901.		10. AGE (In years lost birthday) 69 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk		14B. KIND OF BUSINESS OR INDUSTRY Courts	
15. MOTHER'S MAIDEN NAME Ella Fitzgerald		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 215-40-3772		18. INFORMANT Mrs. Mae Carney	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E9651X		CAUSE OF DEATH (A) IMMEDIATE CAUSE Gunshot wound of head DUE TO, OR AS A CONSEQUENCE OF: (B) _____ (C) _____	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No		22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> UNDERLYING <input type="checkbox"/> CONTRIBUTING	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) vacant lot		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 5100 blk Harford Road	
22D. TIME OF INJURY (APPROX.) 4-30 or 5-1-71		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Shot self		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED May 2, 1971		24A. BURIAL CREMATION, REMOVAL (Specify) Burial	
24B. DATE 5/5/71.		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. MAY 5 1971	
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc.	
ADDRESS Balto. Md. 21214			

VALLEY FORGE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4317	
<div style="display: flex; justify-content: space-between;"> C-615 71 4317 71 4317 </div>					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) WILLIAM B. CRAVENS			2. DATE AND HOUR OF DEATH 4-30-71 6:00 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE ILLINOIS B. COUNTY VANDERBILT		
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL			C. CITY OR TOWN VILLA PARK		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 44			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER 619 N. ADAMS ROAD					
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-11-08	9. AGE (in years last birthday) 62	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Prop: Cravens Label Holder Co.			11. BIRTHPLACE (State or foreign country) KENTUCKY		
13. FATHER'S NAME FURMAN CRAVENS			12. CITIZEN OF WHAT COUNTRY? USA		
14. MOTHER'S MAIDEN NAME MARTHA VIRGINIA OWENS					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE			16. SOCIAL SECURITY NO. -		
17. INFORMANT Mrs. William B. Cravens, Villa Park, Ill.			ADDRESS MEDICAL RECORD		
18. 4-12-71 12:50 P.M. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). DIABETES MELLITUS					
19A. DATE OF OPERATION -		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examined) -		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -	
22. I certify that (X) (this hospital) attended the deceased from 4-19 19 71 to 4-30 19 71 that (I) (X) last saw the deceased alive on 4-30 19 71 and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (X) (did) (did not) view the body after death.					
23A. SIGNATURE Lester A. Reid, M.D.			23B. DATE SIGNED 4-30-71		
23C. PHYSICIAN'S NAME (Type) LESTER A. REID, M.D.			23D. ADDRESS UNION MEMORIAL HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/4/71		24C. NAME of CEMETERY or CREMATORY Chapel Hill Gardens (West)	
24D. LOCATION Elmhurst, Illinois.					
25A. DATE REC'D BY HEALTH DEPT. MAY 5 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214	

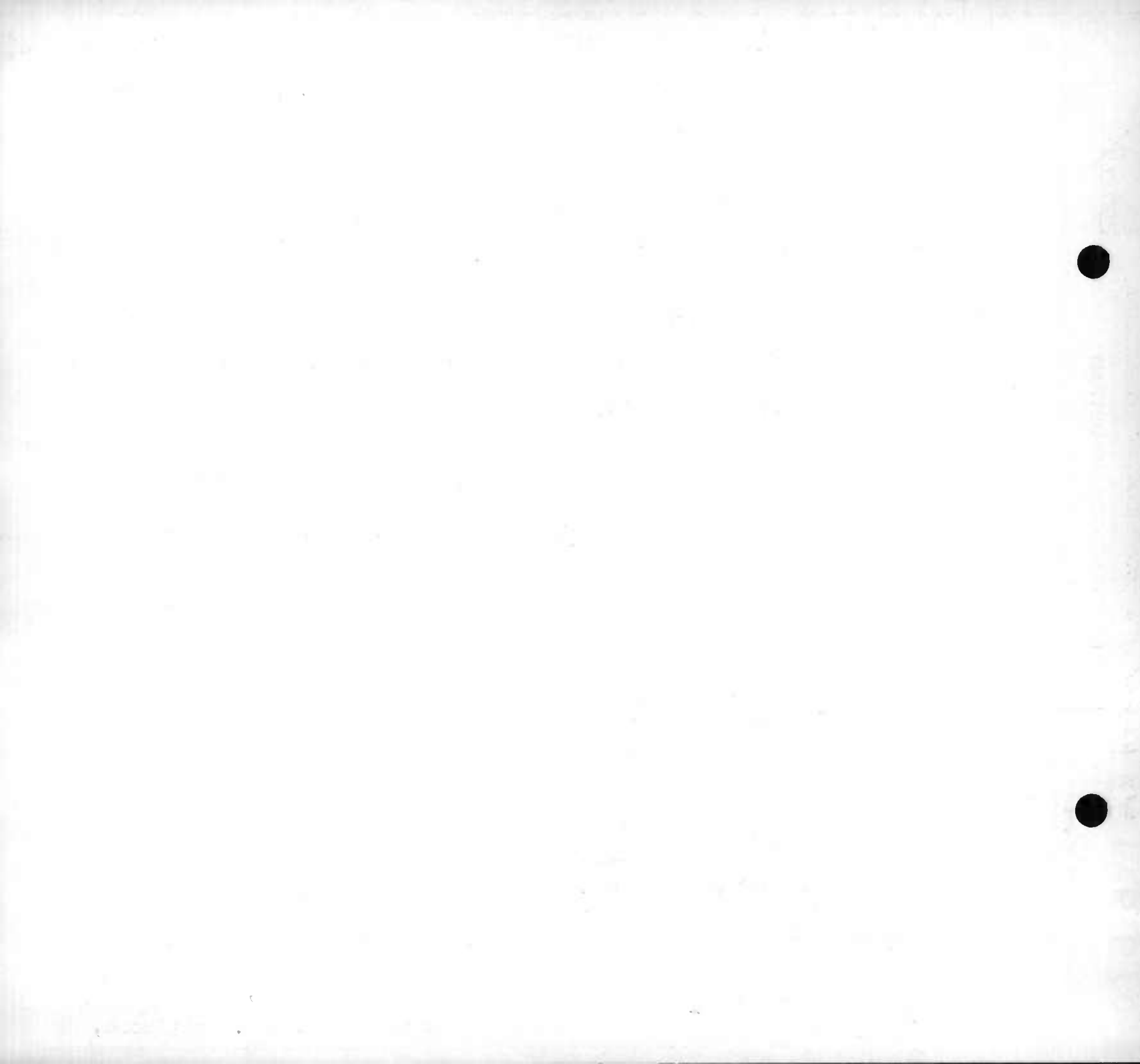


Body released by the medical examiner.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		71 4318		REG. NO. 71 4318	
BIRTH NO. W-340		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Mr. GEORGE A WEIDEL			2. DATE AND HOUR OF DEATH 5/1/71 12:40 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD UNION MEMORIAL Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 2745		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL Hospital			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3403 Royston Avenue		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/23/07	9. AGE (In years last birthday) 64
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10B. KIND OF BUSINESS OR INDUSTRY Nat'l Brewery		11. BIRTHPLACE (State or foreign country) GERMANY	
13. FATHER'S NAME Mr. Lawrence Weidell		14. MOTHER'S MAIDEN NAME XXXXXXXXXX Clemetine Erlanger			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 11		16. SOCIAL SECURITY NO. 215-03-9036		17. INFORMANT wife	
				ADDRESS same	
18. 44791 CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) hypovolemic shock			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Ruptured aortic aneurism			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 5/1/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Poor		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/30 19 71 to 5/1 19 71 that (I) (we) last saw the deceased alive on 5/1 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED 5/1/71	
23C. PHYSICIAN'S NAME (Type) Dr. E. Foster				23D. ADDRESS UNION MEMORIAL Hospital?	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/4/71		24C. NAME OF CEMETERY or CREMATORY Gardens Of Faith	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE RECD BY HEALTH DEPT. MAY 5 1971		25B. NAME OF REGISTRAR Leonard J. Ruck Inc.		25C. FUNERAL DIRECTOR ADDRESS Baltimore, Md	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4319	
C-462 71 4319				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Lucress M Clark</u>		2. DATE AND HOUR OF DEATH <u>5-3-71</u> <u>12²⁵ P.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1744</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>48 Maryland General Hosp</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>5505 Carter Ave</u>		
5. SEX <u>F</u>	6. RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-29-01</u>		9. AGE (In years last birthday) <u>69</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>USA, Maryland</u>	
13. FATHER'S NAME <u>? Speights</u>			14. MOTHER'S MAIDEN NAME <u>? ?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service] <u>no</u>		16. SOCIAL SECURITY NO. <u>215-01-4312</u>		17. INFORMANT <u>Mr James P Clark</u> ADDRESS <u>Same</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardiogenic & Hypertensive Shock</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>PULMONARY EMBOLISM, IN INFUSION</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Diabetes, hypertension</u>			(B) DUE TO, OR AS A CONSEQUENCE OF:		
19A. DATE OF OPERATION <u>NO</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) <u>no</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) [APPROX.]		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4-21</u> 19 <u>71</u> to <u>5-3</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>5-3</u> 19 <u>71</u> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>W. Houghton MD</u>			23B. DATE SIGNED <u>5-3-71</u>		
23C. PHYSICIAN'S NAME (Type) <u>HOUGHTON</u>			23D. ADDRESS <u>MD. GENERAL HOSPITAL</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/6/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Bel Air Memorial Gardens</u>	
24D. LOCATION <u>Beth Air</u>		24E. LOCATION <u>Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 5 1971</u>		25B. NAME OF REGISTRAR <u>Robert A. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Baltimore, MD</u>	

Handwritten text, possibly a signature or date, located in the center of the page.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-630 71 4320 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		71 4320 REG. NO.	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) Lillian C. Hart		2. DATE AND HOUR OF DEATH May 3, 1971 8:40 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION 90 Gould Convalesarium IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 5-13-71		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 902 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1610 Ralworth Rd	
5. SEX Female 6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/14/74 1889 9. AGE (in years last birthday) 81	10. UNDER 1 Yr. Months Days 11. UNDER 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed		10B. KIND OF BUSINESS OR INDUSTRY Dining Room	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Chesney		14. MOTHER'S MAIDEN NAME Myrtle Michaels	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212/22/2364	17. INFORMANT Mrs. Morris T. Hunter same
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 269.9+1003.9 Senile Brain Syndrome 3 yrs. (malnutrition secondary)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic Salmonella enteritis 6 mos Valvular Heart D.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II		(B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-24 1968 to 5-3 1971 that (I) (we) last saw the deceased alive on 2-27 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE W P Benson Jr.		23B. DATE SIGNED 5-4-71	
23C. PHYSICIAN'S NAME (Type) William P Benson M.D.		23D. ADDRESS 3506 North Calvert St Baltimore, Md	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 5-6-1971	24C. NAME OF CEMETERY OR CREMATORY Mt. Zion Cem.	24D. LOCATION (City, town, or county) (State) Fountain Green, Md.
25A. DATE REC'D BY HEALTH DEPT. MAY 5 1971	25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	25C. FUNERAL DIRECTOR Leonard J. Ruck Inc. Baltimore, Md	

V.S. 153

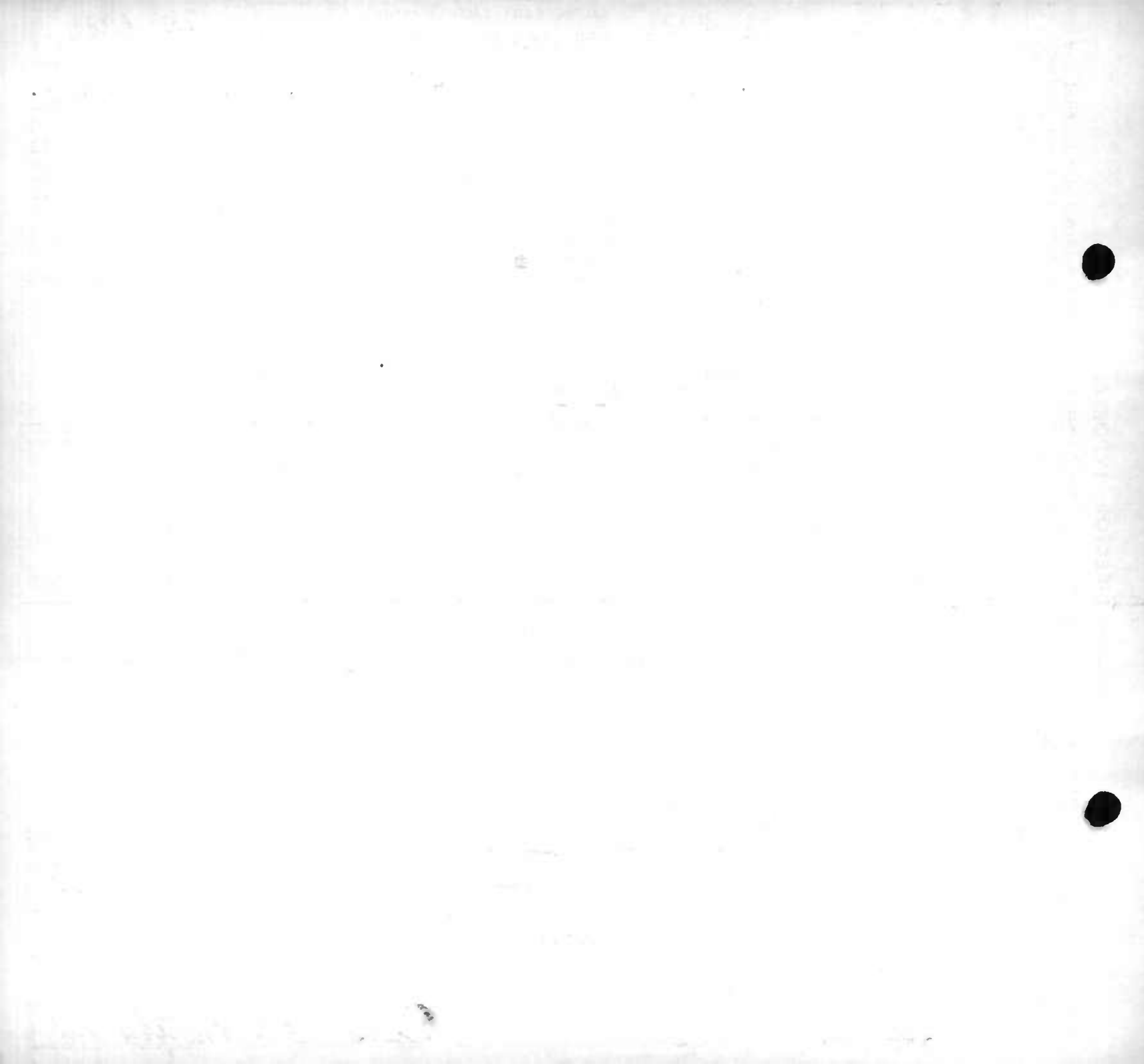
5-13-71

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

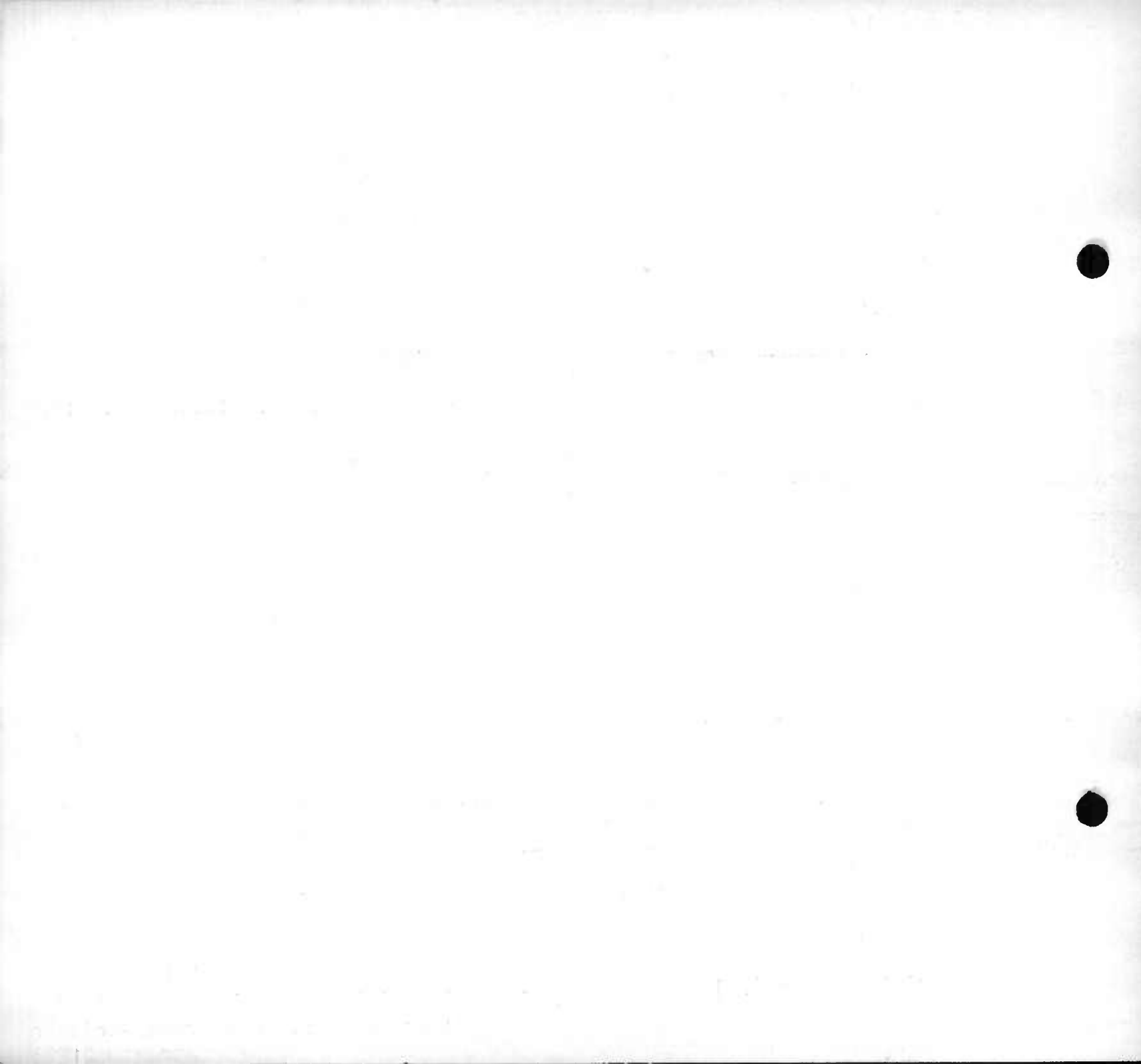
BALTIMORE CITY HEALTH DEPARTMENT				71 4321	
CERTIFICATE OF DEATH				REG. NO. 71 4321	
BIRTH NO. <u>M-420</u>		1. NAME OF DECEASED (Type or Print) <u>Greece G. Mills</u>			
2. DATE AND HOUR OF DEATH <u>May 3, 1971</u> <u>12:55P</u> M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		A. STATE <u>Maryland</u> B. COUNTY <u>1202</u>	
5. SEX <u>F</u>		6. RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH <u>26 Nov 88</u>		9. AGE (In years lost birthday) <u>82</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newspaper Supply</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY <u>US</u>		13. FATHER'S NAME <u>John H. Gibson</u>	
14. MOTHER'S MAIDEN NAME <u>Alice G. Lamb</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>062-16-5003</u>	
17. INFORMANT <u>Hospital Clerk</u>		ADDRESS			
18. <u>170.7 I</u> CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Hypertension - Cardiac failure</u>		<u>2 hours</u>	
ANTECEDENT CAUSES		(B) <u>Pathologic Fr @ femur</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>1 day</u>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <u>Concussion</u>		<u>3 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>2 May</u> 19 <u>71</u> to <u>3 May</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>2 May</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Tr. - R...</u>		23B. DATE SIGNED <u>3 May 71</u>		23C. PHYSICIAN'S NAME (Type) <u>Thomas H. Pouch</u>	
23D. ADDRESS <u>2 E. Road St - 21202</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>5/6/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>		24D. LOCATION (City, town, or county) <u>Baltimore Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 5 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Trucks</u> ADDRESS <u>5300 Hartford Rd.</u>	



FUNERAL DIRECTOR: IMPORTANT

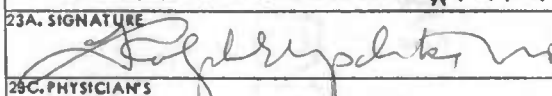
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4322	
BIRTH NO. 11-600		71 4322		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) MAYER, ELIZABETH C.			2. DATE AND HOUR OF DEATH 5/2/71 3:28 pm		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 1903		
FULL NAME OF HOSPITAL OR INSTITUTION 34 Bon Secours Hospital			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX F			6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			8. DATE OF BIRTH 11-22-85		9. AGE (in years last birthday) 85
10B. KIND OF BUSINESS OR INDUSTRY 			11. BIRTHPLACE (State or foreign country) Hungary		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME ----- Kocher			14. MOTHER'S MAIDEN NAME Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 218-62-7587		17. INFORMANT Mary Payne 407 So. Vincent St. 21223
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE Myocardial Infarction and Cognitive Heart Failure DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Cardiovascular Disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: 		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Pneumonia?			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 		
19A. DATE OF OPERATION 		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 4-14 19 71 to 5-2 19 71 that (H) (we) last saw the deceased alive on 5-2 19 71 and that (H) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lidia L. de Borja M.D.			Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5-2-71
23C. PHYSICIAN'S NAME (Type) Lidia L. de Borja M.D.			23D. ADDRESS Bon Secours Hosp. Balto Md. 21223		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/5/71		24C. NAME OF CEMETERY or CREMATORY German Evang. Luth. Cem. Baltimore City & County, Md.	
24D. LOCATION (City, town or county) (State) Violetville		25A. DATE REC'D BY HEALTH DEPT. MAY 5 1971			
25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR Walters Funeral Home Pratt & Stricker			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>71 4323</u>	
BIRTH NO. <u>R-250</u> <u>71 4323</u>				1. NAME OF DECEASED (Type or Print) RUSIN, GEORGE CHARLES JR.		2. DATE AND HOUR OF DEATH MAY 2 1971 11:10AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY Anne Arundel C. CITY OR TOWN GLEN BURNIE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 4 WEST PARK COURT 21061			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/05/13		9. AGE (In years last birthday) 57	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST		10B. KIND OF BUSINESS OR INDUSTRY Humble Oil Co. SERVICE STATION		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME GEORGE RUSIN				14. MOTHER'S MAIDEN NAME FRANCES BAYMAR			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220 07 2596		17. INFORMANT ADDRESS ST AGNES HOSPITAL BALTO MD 21229			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH Carcinoma Lung - metastatic		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr	
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A)							
19A. DATE OF OPERATION 2/1		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX) 1Month 1Day 1Year 1Hour		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that XX (this hospital) attended the deceased from 04/25/71 19 to 05/02/71 19 that (X) (we) last saw the deceased alive on 05/02/71 19 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (X) view the body after death.							
23A. SIGNATURE  23C. PHYSICIAN'S NAME (Type) RALPH UPDIKE MD						23B. DATE SIGNED 05/02/71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/5/71		24C. NAME of CEMETERY or CREMATORY Sacred Heart of Jesus		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 5 1971		25B. NAME OF REGISTRAR John J. Duda		25C. FUNERAL DIRECTOR ADDRESS 7922 Wise Ave. Dundalk, Md.			

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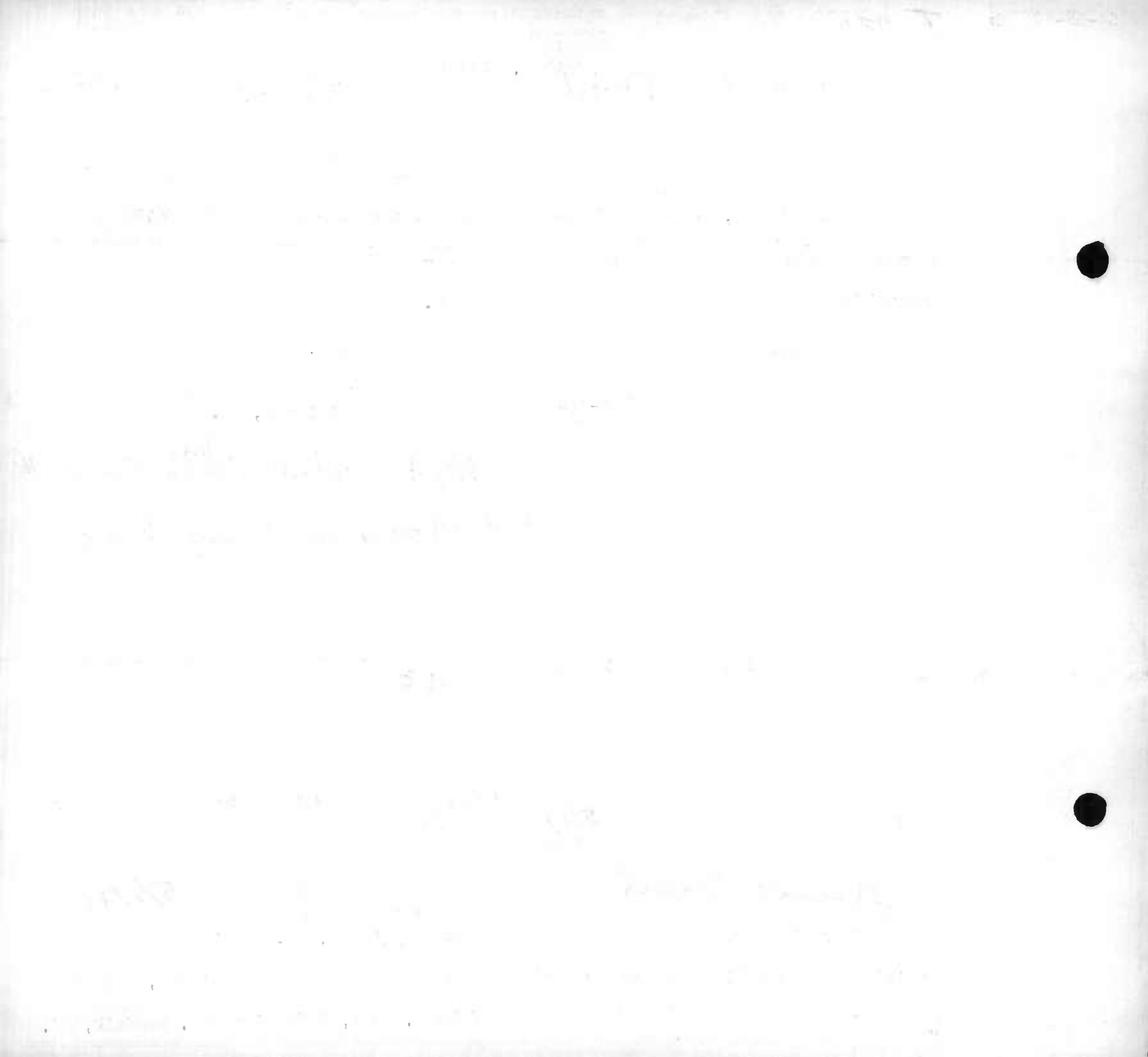
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-232 71 4324		BALTIMORE CITY HEALTH DEPARTMENT		71 4324	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <i>Ruth C. Tkatch</i>		2. DATE AND HOUR OF DEATH <i>5/1/71</i>		<i>8:00 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <i>31</i> BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>Dundalk</i> D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>1920 Inverton Road 21222 007</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-25-21</i>	9. AGE (in years last birthday) <i>49</i>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Tenn.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>John Hixson</i>		14. MOTHER'S MAIDEN NAME <i>Mamie Layne</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>407-16-1899</i>		17. INFORMANT ADDRESS <i>BCH-Records 4940 Eastern Avenue Baltimore, Md. 21224</i>	
18. <i>16-2-1 I</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE <i>Hepatic metastases + liver failure</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Distal carcinoma of lung</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>One month</i> <i>5 mos.</i>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (A) (this hospital) attended the deceased from <i>4/28</i> 19 <i>71</i> to <i>5/1</i> 19 <i>71</i> that (B) (we) last saw the deceased alive on <i>5/1/71</i> and that (C) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (D) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Russell Harris</i>		23B. DATE SIGNED <i>5/1/71</i>		23C. PHYSICIAN'S NAME (Type) <i>Russell Harris</i>	
23D. ADDRESS <i>BCH- Baltimore, Md. 21224</i>		23E. NAME OF REGISTRAR <i>John J. Duda</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5/4/71</i>		24C. NAME of CEMETERY or CREMATORY <i>Gardens of Faith Cemetery</i>	
24D. LOCATION <i>Baltimore, Maryland</i>		24E. FUNERAL DIRECTOR ADDRESS <i>7922 Wise Ave. Dundalk, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 5 1971</i>		25B. NAME OF REGISTRAR <i>John J. Duda, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>7922 Wise Ave. Dundalk, Md.</i>	



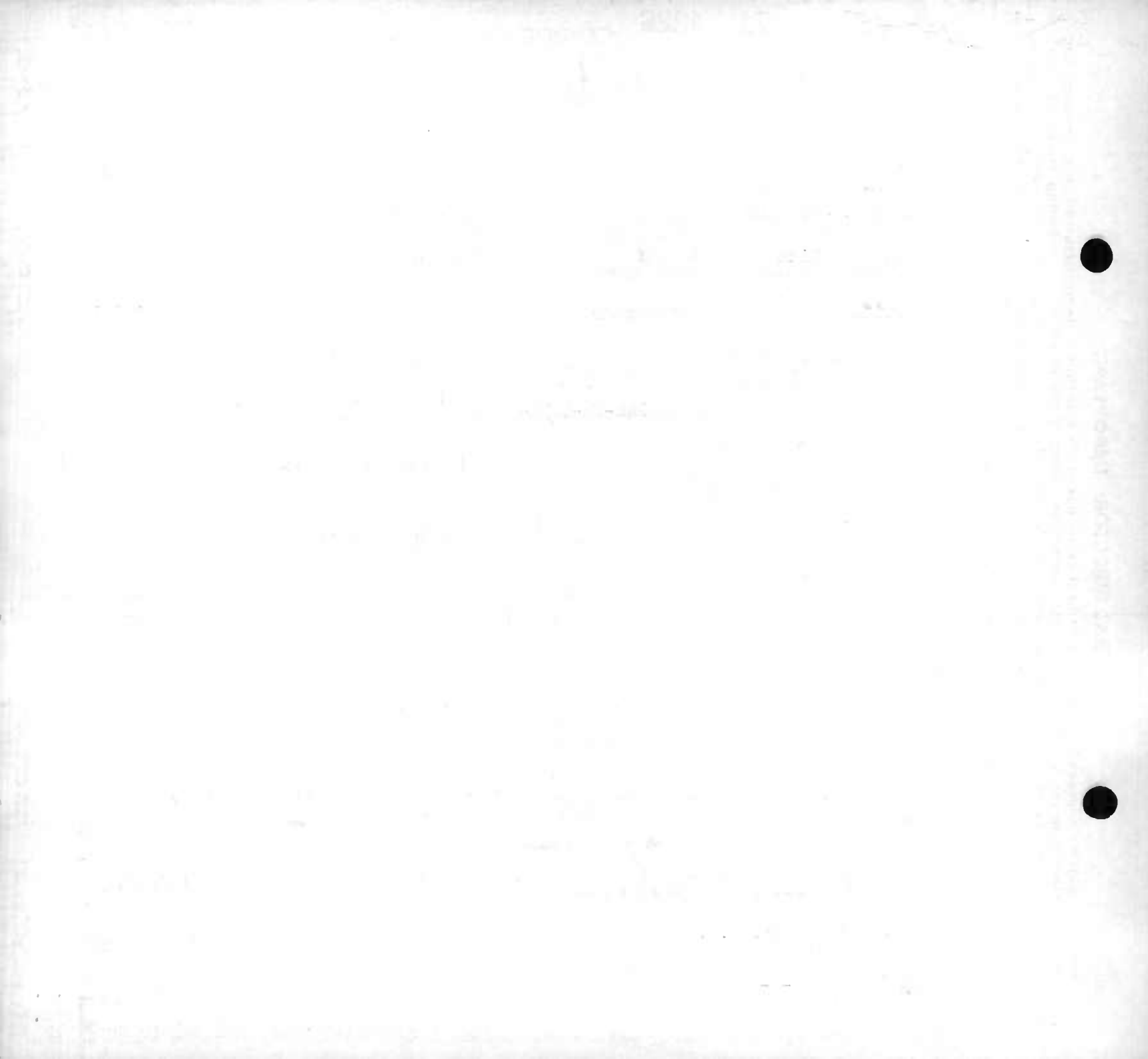
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4325	
M-000 71 4325				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>George Leonard MAY</u>		2. DATE AND HOUR OF DEATH <u>5/1/71</u> <u>18¹⁰</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Pa</u> B. COUNTY <u>V-35</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>US PHS Hospital</u> <u>2X</u>			C. CITY OR TOWN <u>Puncansville</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>RD2</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/20/05</u>	9. AGE (in years last birthday) <u>66</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pa</u>	
13. FATHER'S NAME <u>George May</u>			14. MOTHER'S MAIDEN NAME <u>Alice Blake</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>167-09-1028</u>		17. INFORMANT <u>US PHS HOSPITAL Wyman Park Dr. Baltimore Md.</u>	
18. <u>20501</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Pneumonia</u>				<u>days</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Acute Myelogenous Leukemia</u>				<u>2 mos.</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>R. Roger Little, MD</u> DEGREE				23B. DATE SIGNED <u>5/2/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>R. Roger Little, MD</u> DEGREE				23D. ADDRESS <u>US PHS Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>5-5-71</u>		24C. NAME of CEMETERY or CREMATORY <u>RIVERVIEW CEMETERY</u>	
				24D. LOCATION (City, town, or county) (State) <u>BLAIR CO., PENNSYLVANIA</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 5 1971</u>		25B. NAME OF REGISTRAR <u>John E. Taylor, R.E.</u>		25C. FUNERAL DIRECTOR <u>HOWARD H. HUBBARD</u> ADDRESS <u>4107 WILKENS AVE. 21229</u>	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

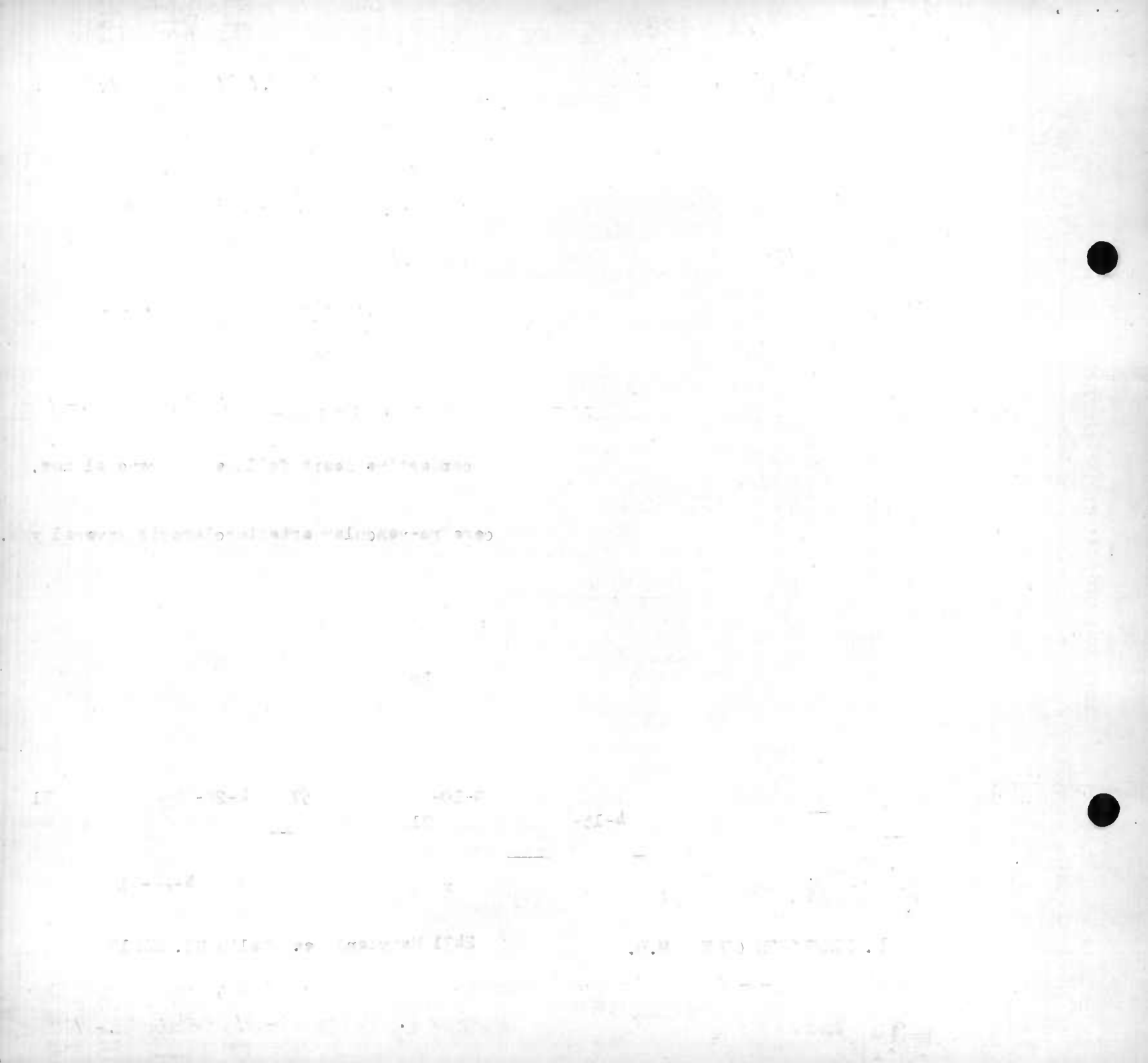
BALTIMORE CITY HEALTH DEPARTMENT				BALTIMORE CITY HEALTH DEPARTMENT		BALTIMORE CITY HEALTH DEPARTMENT	
71 4326				71 4326		71 4326	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Sophie Martin				5/2/71 8:50 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland				Maryland Baltimore			
5. SEX				6. DATE OF BIRTH		9. AGE (In years last birthday)	
Female				11-13-85		85	
7. RACE				10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
White				Housewife		Homemaker	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
New York				U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
William Anton Peterson				Hannah Rustin			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
No				111-07-2632-D		4940 Eastern Avenue BCH: Records Baltimore, Maryland 21224	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE			
[This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.]				Pneumonia			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Pulmonary emboli			
II				Parkinson's Disease			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				15 yrs.			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2						YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from 4/20 19 71 to 5/2 19 71							
that (1) (we) last saw the deceased alive on 5/2 19 71 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Russell Harris, M.D.				5/2/71			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Russell Harris, M.D.				Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial				5-4-71		Evergreen Cemetery	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAY 5 1971						Lassahn Funeral Home 7401 Belair Road 21236	
25D. ADDRESS				25E. ADDRESS			
				Balto.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4327	
<div style="display: flex; justify-content: space-between;"> B-651 71 4327 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Minnie L. Brumfield		April 28, 1971 1:15 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
00 744 E. 30th Street				Maryland 904	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		744 E. 30th Street-21218			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	July 22, 1904	66	U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired				West Virginia	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Owen Cremeans			Mary Pritchard		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		233-30-4862		Walter V. Stowers - 8821 Victory Ave.-21234	
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>I</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 50%;"> <p>(A) IMMEDIATE CAUSE</p> <p>congestive heart failure several mos.</p> <p>(B) ^bcore-re-vascular arteriosclerosis several yrs.</p> <p>(C) _____</p> </div> </div>					
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 9-10-19 57 to 4-28-19 71, that (I) (we) last saw the deceased alive on 4-15-19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
E. Ellsworth Cook				4-28-71	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
E. ELLSWORTH COOK M.D.				2431 Maryland Ave Balto Md. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		5-1-71		Parkwood Cemetery	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAY 5 1971		John C. Miller		415 Belair Rd.-21206	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-650 71 4328				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 71 4328	
BIRTH NO.				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <u>John E Karn</u>				2. DATE AND HOUR OF DEATH <u>5-3-71</u> <u>3:10</u> <u>A.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>48 Maryland General Hospital</u>		(If not in hospital or institution, give street address or location)		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Annapolis</u>	
				D. STREET ADDRESS (If rural, give location) <u>1086 Broadview Dr. Route 4</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>10-12-1887</u>	9. AGE (In years last birthday) <u>83</u>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Burkittsville, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John E Karn</u>				14. MOTHER'S MAIDEN NAME <u>Pearl</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>213-07-6523</u>		17. INFORMANT ADDRESS <u>Ezra Leroy Karn-1086 Broadview Drive</u>		
18. <u>436917-185X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <u>Cerebrovascular accident</u> DUE TO <u>Pulmonary edema</u> DUE TO <u>Carcinoma of Prostate</u>				CAUSE OF DEATH <u>Annapolis, Maryland</u> INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>5-2</u> <u>19 71</u> to <u>5-3</u> <u>19 71</u> , that (I) (we) lost saw the deceased alive on <u>5-2</u> <u>19 71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>AJ Sequeira</u>				M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>5-3-1971</u>	
23C. PHYSICIAN'S NAME (Type) <u>Alejandro J. Sequeira</u>				23D. ADDRESS <u>Maryland General Hospital</u>			
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-5-1971</u>		24C. NAME of CEMETERY or CREMATORY <u>Burkittsville Union Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Burkittsville, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 5 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Armacost Funeral Chapel -4600 Liberty Hts</u>			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

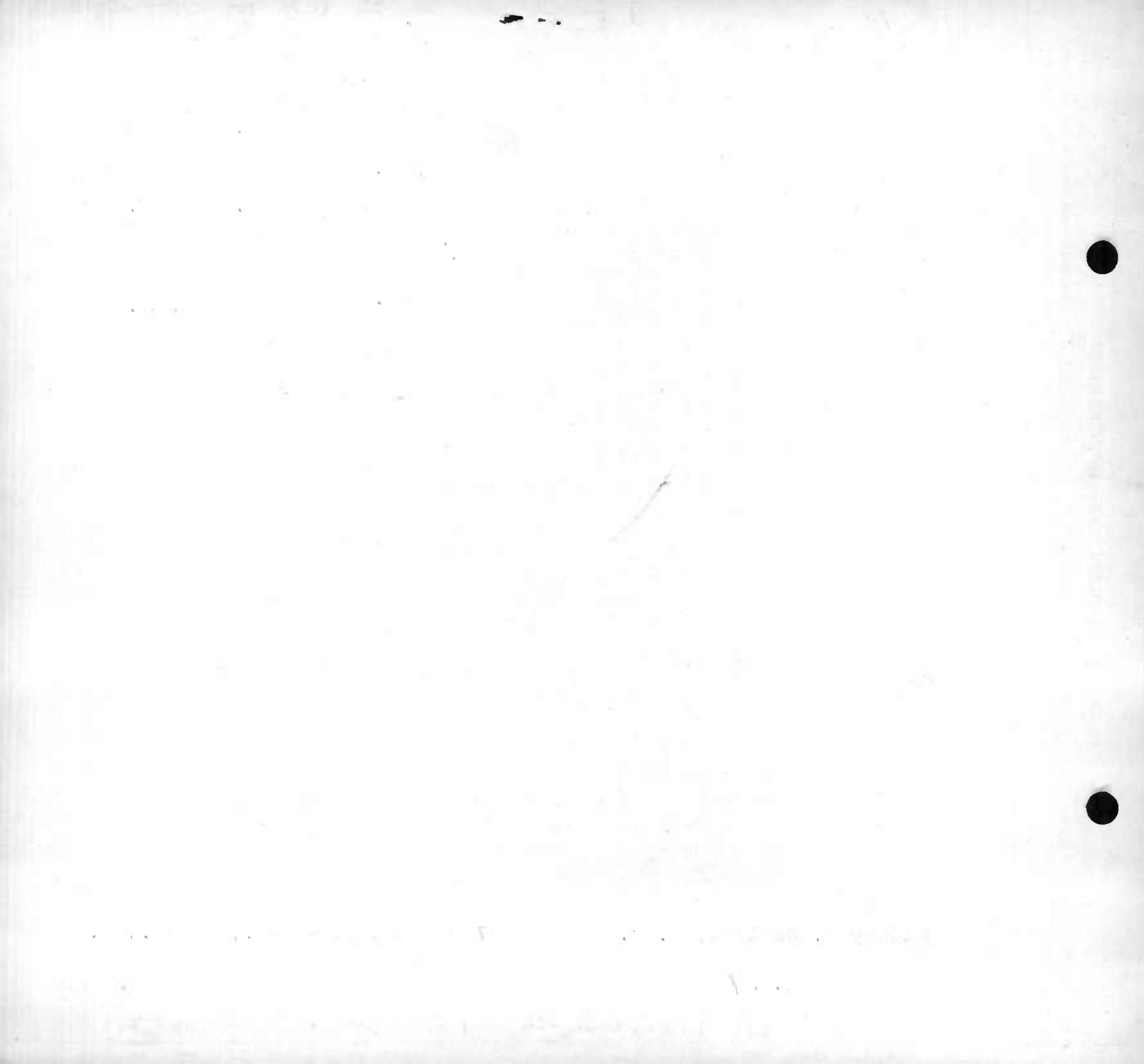
S-200 71 4329		BALTIMORE CITY HEALTH DEPARTMENT		71 4329	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
SACKS, BENJAMIN D ₂		2 nd MAY 1971 4:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
SINAI HOSPITAL OF BALTIMORE INC. 42		Md B ₂ HO.		5300	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	
M		C		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Physician				Aug 14, 1896 74 yrs	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (in years last birthday)	
Louis		Fannie		74 yrs	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO		572-341940		Hosp Clerk	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
I		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		3 months	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 2-22-1971 to 5-2-1971 that (I) (we) last saw the deceased alive on 5-2-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Prasad		5/2/71			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
PPRASAD MBBS		Sinai Hospital, Baltimore, Md 21215			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		5/4/71		Beth Tfelok	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAY 5 1971		Robert E. Taylor, M.D.		Sylvan Lewis 2501 IWC 9610 Kensington Rd	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 616 71 4330				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 4330	
1. NAME OF DECEASED (Type or Print) <i>Susanna Travers</i>				2. DATE AND HOUR OF DEATH <i>5/4/71</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>43 South Balto Gen Hospital</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>BALTO</i> <i>206 Greenland Beach Rd. 5200</i>			
				C. CITY OR TOWN <i>Balto, Md. 21226</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>206 Greenland Beach Rd. Balto Md. 21226</i>			
5. SEX <i>F</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 15 1897</i>		9. AGE (In years last birthday) <i>73</i>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Balto Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Peters</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Hamilton</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>N/A</i>		16. SOCIAL SECURITY NO. <i>215 07 4720 D</i>		17. INFORMANT <i>Miss Catherine Travers</i>		ADDRESS <i>As Above</i>	
18. <i>410.9 + 250.9</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Myocardial infarction</i> (B) <i>A.S.C.V. disease</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Diabetes mellitus</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 hours</i> <i>10 years</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>19 48</i> to <i>5/4</i> 19 <i>71</i> , that (I) (we) last saw the deceased alive on <i>4/22</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Sidney R. Gehlert, M.D.</i>				23B. DATE SIGNED <i>5/5/71</i>		23C. PHYSICIAN'S NAME (Type) <i>Sidney R. Gehlert, M. D.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5.7.71</i>		24C. NAME of CEMETERY or CREMATORY <i>Cedar Hill Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Rithie Hwy Balto Md. 21225</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 6 1971</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Mcully Funeral Home 237 Patapsco Ave</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 10-320 71 5300 71 4331				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 4331	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
WATTS, MICHAEL JAMES				MAY 3 1971 1:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
ST. AGNES HOSPITAL CATON & WILKENS AVENUE BALTIMORE MARYLAND 21229				MARYLAND			
5. SEX MALE				6. DATE OF BIRTH 03 30 71		7. AGE (in years last birthday) 1 3	
8. RACE WHITE				9. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		10. UNDER 1 Yr. Months Days	
11. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				12. BIRTHPLACE (State or foreign country) MARYLAND		13. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BABY				15. KIND OF BUSINESS OR INDUSTRY none			
16. FATHER'S NAME OSBORNE W. WATTS JR				17. MOTHER'S MAIDEN NAME SANDRA LEE (AULT) WATTS			
18. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				19. SOCIAL SECURITY NO.			
20. INFORMANT WILKENS AVENUE BALTO MD 21229				ADDRESS ST AGNES HOSPITAL RECORDS CATON &			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				Respiratory arrest			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				Congenital anomaly			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____				1 month 3 days			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				_____			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Congenital heart disease, No thrombosis	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from MARCH 30 1971 to MAY 3 1971 that (I) (we) last saw the deceased alive on MAY 3 1971 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.							
23A. SIGNATURE YUPADRE VORASUBTN				23B. DATE SIGNED 5.3.71		23C. PHYSICIAN'S NAME (Type) YUPADRE VORASUBTN	
23D. ADDRESS 21. Agn Hosp.				23E. FUNERAL DIRECTOR John J. Corran & Son Inc. 901 Hollins St. 33 md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/4/71		24C. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.		24D. LOCATION (City, town, or county) (State) Glen Burnie Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 5 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR John J. Corran & Son Inc. 901 Hollins St. 33 md.			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
M-622 71 4332		71 4332			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		DATE	
MARQUESS, PERCY		6:10 P.M.		4-30-71 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
University of Maryland Hospital BALTIMORE MARYLAND 21201		Md.		Calvert	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	
M		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
5/12/1903		67		Fisherman	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
Maryland		USA		Millard Marquess	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Susan Chaney		No			
17. INFORMANT		18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
University Hospital Baltimore Maryland 21201		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Thoracic aneurysm, ascending (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		20. AUTOPSY? (Yes or No)		21. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
4-30-71		NO			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE		23B. DATE SIGNED	
Rostam Fardin M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify)	
ROSTAM FARDIN M.D.				Burial	
24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
MAY 5 1971		Smithville Cem.		Dunkirk, Cal. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAY 5 1971		J. E. Taylor, R.D.		Buchanan-Hutchins F. H.	
				ADDRESS Owings, Md.	



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 4333</u>
BIRTH NO. <u>M-324 71 4333</u>		1. NAME OF DECEASED (Type or Print) <u>JEROME MITCHELL</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>5 CHURCH HOME AND HOSPITAL</u>		2. DATE AND HOUR OF DEATH <u>MAY 3, 1971</u> <u>6:35 P.M.</u>		
4. USUAL RESIDENCE (Where deceased lived, if institution's residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>301</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <u>1400 E. BALTIMORE ST.</u>				
5. SEX <u>M</u>	6. RACE <u>B</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>unknown</u>	9. AGE (in years last birthday) <u>95</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>unknown</u>		11. BIRTHPLACE (State or foreign country) <u>unknown</u>
12. CITIZEN OF WHAT COUNTRY <u>—</u>		13. FATHER'S NAME <u>unknown</u>		
14. MOTHER'S MAIDEN NAME <u>unknown</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>unknown</u>		
16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Mildred Dickerson</u> ADDRESS <u>1400 E. Baltimore</u>		
18. I <u>2879</u> <u>I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Probable Septic shock</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Ulcerations, necrosis & infection both legs.</u> <u>Serious malnutrition & dehydration</u> <u>Rt upper lobe pneumonia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> <u>unknown</u> <u>unknown</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Rt upper lobe pneumonia</u>				
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>5-2-1971</u> to <u>5-3-1971</u> that (I) <u>(we)</u> last saw the deceased alive on <u>5-3-1971</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour end from the causes stated above. (I) <u>(We did)</u> (did not) view the body after death.				
23A. SIGNATURE <u>Rustum Irani</u> M.D. DEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED <u>5-3-1971</u>	
23C. PHYSICIAN'S NAME (Type) <u>RUSTUM IRANI</u> M.D. DEGREE		23D. ADDRESS <u>CHURCH HOME AND HOSPITAL</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>5/7/71</u>	24C. NAME OF CEMETERY OR CREMATORY <u>MT Calvary Cemtry</u>	24D. LOCATION (City, town, or county) (State) <u>A A County Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 5 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>	25C. FUNERAL DIRECTOR <u>A Halstead</u> ADDRESS <u>1206 W North Ave</u>	



1

M-24 71 4334 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 4334

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Mossie McKelvy		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 5 Day 2 Year 71 Hour 2:30 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland Gen. Hosp.		3. DATE PRONOUNCED DEAD Month 5 Day 2 Year 71 Hour 2:30 p.m.	
6. SEX female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1301	
9. DATE OF BIRTH 1/16/13		10. AGE (In years lost birthday) 58	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF U.S. COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of life, even if retired) Domestic		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
15. MOTHER'S MAIDEN NAME Lela		18. INFORMANT Mrs Allen, Same	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute massive pulmonary embolism ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 5/3/71 ACTUAL SIGNATURE: Peter Lipkovic, M.D. EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/8/71	
24C. NAME OF CEMETERY or CREMATORY Mt Auburn C. metry		24D. LOCATION (City, town, or county) (State) Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT. MAY 5 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR A. Halstead 1206 W North Ave		ADDRESS	

VS 151-REV. 1/1/68

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 4335	
C-455 71 4335				REG. NO. 71 4335	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)	
				FLOYD COLEMAN	
2. DATE AND HOUR OF DEATH				05-01-71 11:00A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205				MARYLAND 703	
5. SEX 6. RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
MALE NEGRO				BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				E. STREET AND NUMBER	
Labor				930 PATTERSON PARK AVE	
10B. KIND OF BUSINESS OR INDUSTRY				8. DATE OF BIRTH	
				10-26-34 36	
11. BIRTHPLACE (State or foreign country)				9. AGE (In years lost birthday)	
South Carolina				36	
12. CITIZEN OF WHAT COUNTRY?				11. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
U.S.A.					
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
JOHN COLEMAN				ANDRENDER MCMEekin	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	
No				247-52-0740	
17. INFORMANT				ADDRESS	
Charles Coleman					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
0					
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
NO					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/1/71 to 5/1/71					
that (I) (we) last saw the deceased alive on 5/1/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
John M. Amatruda MD				5/1/71	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
John M. Amatruda MD				601 N. Broadway	
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE	
Burial				5-5-71	
24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)	
Mt Calvary Cmt				Balt md	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR	
MAY 5 1971				John E. [unclear]	
25C. FUNERAL DIRECTOR				ADDRESS	
[unclear]				[unclear]	

1890

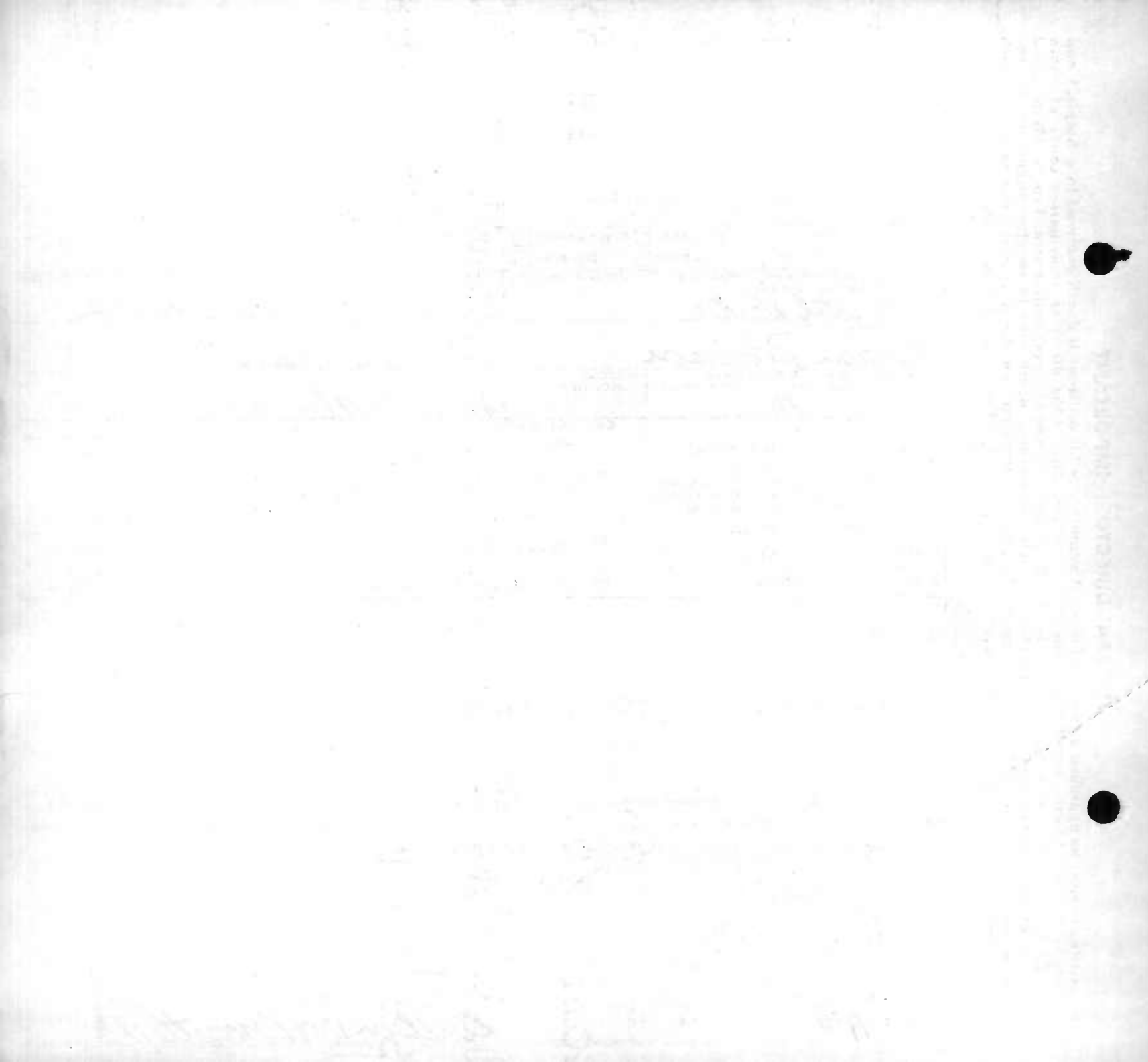
Robert Johnson
John Johnson

CC 211
J. M. Johnson
J. M. Johnson

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 71 4336	
1. NAME OF DECEASED (Type or Print) <i>Edith Miller</i>		2. DATE AND HOUR OF DEATH <i>5-3-71</i> <i>8:10 AM</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>33 The Johns Hopkins Hospital</i>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>802</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>1627 Milton Avenue</i>			
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/23/24</i>	9. AGE (In years last birthday) <i>46</i>	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Hospital Worker</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Durham N. Carolina U.S.A.</i>	
13. FATHER'S NAME <i>Theodore Robinson</i>		14. MOTHER'S MAIDEN NAME <i>Thelma Polansky</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>James Miller 1201 Eden St</i>	
18. <i>431.0 17-250.9</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Cerebral herniation 20</i> <i>Outlying mass</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Intrauterine, intracerebral bleed</i> <i>Hypertension</i> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Diabetes Mellitus A.O.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>240</i> <i>48hr</i> <i>>10y</i> <i>5 days</i>			
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <i>(this hospital)</i> attended the deceased from <i>4/29</i> 19 <i>71</i> to <i>5/3</i> 19 <i>71</i> that (I) (we) last saw the deceased alive on <i>5/3</i> 19 <i>71</i> and that (in my) <i>(our)</i> opinion death occurred on the date and hour and from the causes stated above (I) (We) <i>(did)</i> did not view the body after death.					
23A. SIGNATURE <i>Bernadine Bulkeley</i>				23B. DATE SIGNED <i>5-3-71</i>	
23C. PHYSICIAN'S NAME (Type) <i>Bernadine Bulkeley MD</i>		23D. ADDRESS <i>Johns Hopkins Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5-6-71</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Catholics</i>	
24D. LOCATION <i>White Mt</i>		24E. (City, town, or county) (State) <i>MD</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 5 1971</i>		25B. NAME OF REGISTRAR <i>John E. Fisher, R.D.</i>		25C. FUNERAL DIRECTOR <i>Corbett & Son</i>	
				ADDRESS <i>1000 Brimley Ave</i>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

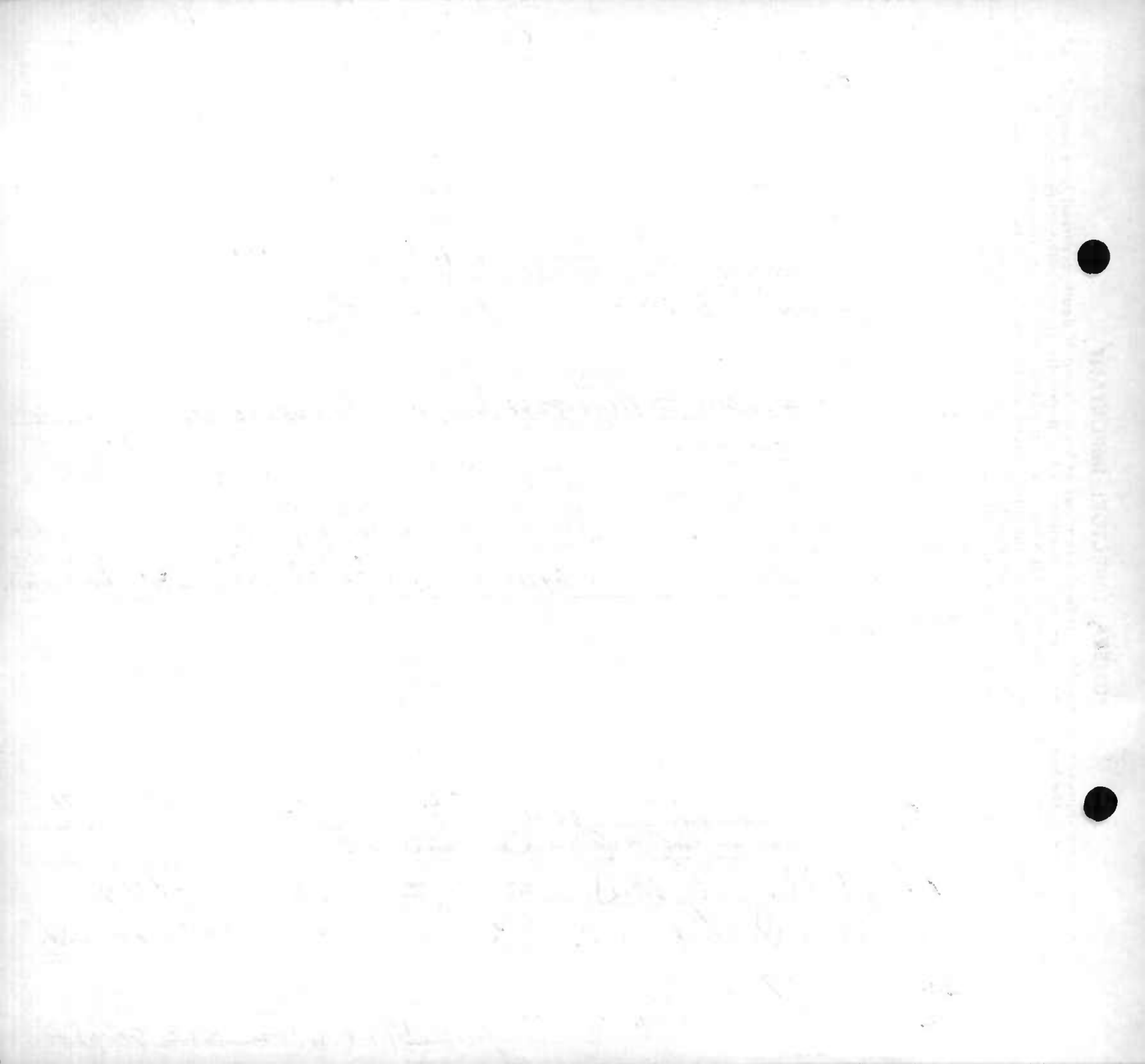
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4337	
C-514 71 4337		BIRTH NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Diana Campbell			2. DATE AND HOUR OF DEATH 5-1-71 5:59p. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY 1702		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 39 Provident Hospital, Inc. 2600 Liberty Heights Avenue Baltimore, Maryland 21215			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 1024 Stoddard Court					
5. SEX Female	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-1-1900	9. AGE (In years last birthday) 71	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Henrietta Edmonds	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 055-22-6007		17. INFORMANT Daniel J. Campbell Sr. ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE CVA + Pulmonary Edema ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last OLD CVA ASCV Disease			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 3 yrs. undetermined		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from April 18, 1971 to May 1, 1971 that (I) (we) last saw the deceased alive on May 1, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Webster Sewell M.D. DEGREE		23B. DATE SIGNED 5-3-71		23C. PHYSICIAN'S NAME (Type) WEBSTER SEWELL DEGREE	
23D. ADDRESS 2600 Liberty Heights Ave. Balto., Md. 21215		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-5-71	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cmt		24D. LOCATION (City, town, or county) (State) Balto Md		25A. DATE REC'D BY HEALTH DEPT. MAY 5 1971	
25B. NAME OF REGISTRAR John E. Fisher, M.D.		25C. FUNERAL DIRECTOR Craig Wilson 1000 Broadway		25D. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				C-534 71 4338		REG. NO. 71 4338	
1. NAME OF DECEASED (Type or Print) Pasquale Condello				2. DATE AND HOUR OF DEATH 5/4/71 11:20 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital 33				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Pennsylvania B. COUNTY V-35 C. CITY OR TOWN Philadelphia D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1937 Sigel Street 19145			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/11/24	9. AGE (In years last birthday) 46	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STONE MASON		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STONE MASON			10B. KIND OF BUSINESS OR INDUSTRY BLOG -		11. BIRTHPLACE (State or foreign country) PHILA Pa		
13. FATHER'S NAME Dominic Condello				14. MOTHER'S MAIDEN NAME Josephine Panzera			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES U.S.A. - WWII. #				16. SOCIAL SECURITY NO. 180-14-8238		17. INFORMANT JOSEPHINE CONDELLO 1937 S. FEL. ST.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Renal Failure				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 Days			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Progressive Systemic Sclerosis (Scleroderma) with Hypertension				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 months			
(B) DUE TO, OR AS A CONSEQUENCE OF: Polymyositis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 months			
(C) Systemic Lupus Erythematosus & Gut Indeterminate				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2/11/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 5/1 19 71 to 5/4 19 71 the (1) (we) last saw the deceased alive on 5/4 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Robert A. Vigersky, M.D.				23B. DATE SIGNED 5/4/71			
23C. PHYSICIAN'S NAME (Type) ROBERT A. VIGERSKY, M.D.				23D. ADDRESS 601 N. BROADWAY, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/8/71		24C. NAME OF CEMETERY OR CREMATORY Holy Cross		24D. LOCATION (City, town, or county) (State) VERDON Pa.	
25A. DATE REC'D BY HEALTH DEPT. MAY 5 1971		25B. NAME OF REGISTRAR Robert A. Vigersky, M.D.		25C. FUNERAL DIRECTOR Jerome M. Della Noce		ADDRESS 322 5th St. H.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>11-420</u> <u>71</u> <u>4339</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>71</u> <u>4339</u>	
1. NAME OF DECEASED (Type or Print) <u>MILICH</u> <u>JERRY OR JEROME</u>				2. DATE AND HOUR OF DEATH <u>5/1/71</u> <u>2 AM</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, or institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>31</u> Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				A. STATE Maryland		B. COUNTY <u>2612</u>	
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 4940 Eastern Ave., Balto. Md. 21224			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1-23-07</u>	9. AGE (In years last birthday) <u>64</u>	10. Under 1 Yr. Months: <u> </u> Days: <u> </u>	11. Under 24 Hrs. Hours: <u> </u> Min: <u> </u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>4940 Eastern Avenue</u> <u>BCH Records: Baltimore, Md. 21224</u>		
18. <u>4-36-9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>CVA</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>cerebral palsy</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>carcinoma of colon</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>(H)</u> (this hospital) attended the deceased from <u>6/10/63</u> 19 <u> </u> to <u>5/1/71</u> 19 <u> </u> that <u>(H)</u> (we) last saw the deceased alive on <u>5/1/71</u> 19 <u> </u> and that <u>(H)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(H)</u> (We) <u>(did)</u> <u>(did not)</u> view the body after death.							
23A. SIGNATURE <u>Joseph Roll</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>5/2/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Joseph Roll, M.D.</u>				23D. ADDRESS <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave., Baltimore, Md. 21224</u>			
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE <u>5/5/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Greenmount</u>		24D. LOCATION (City, town, or county) (State) <u>Balto</u> <u>Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 5 1971</u>		25B. NAME OF REGISTRAR <u>John E. Kelly</u>		25C. FUNERAL DIRECTOR <u>Jerome M. Dellaporta</u>		ADDRESS <u>3225 Highland</u>	

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Frank Bell

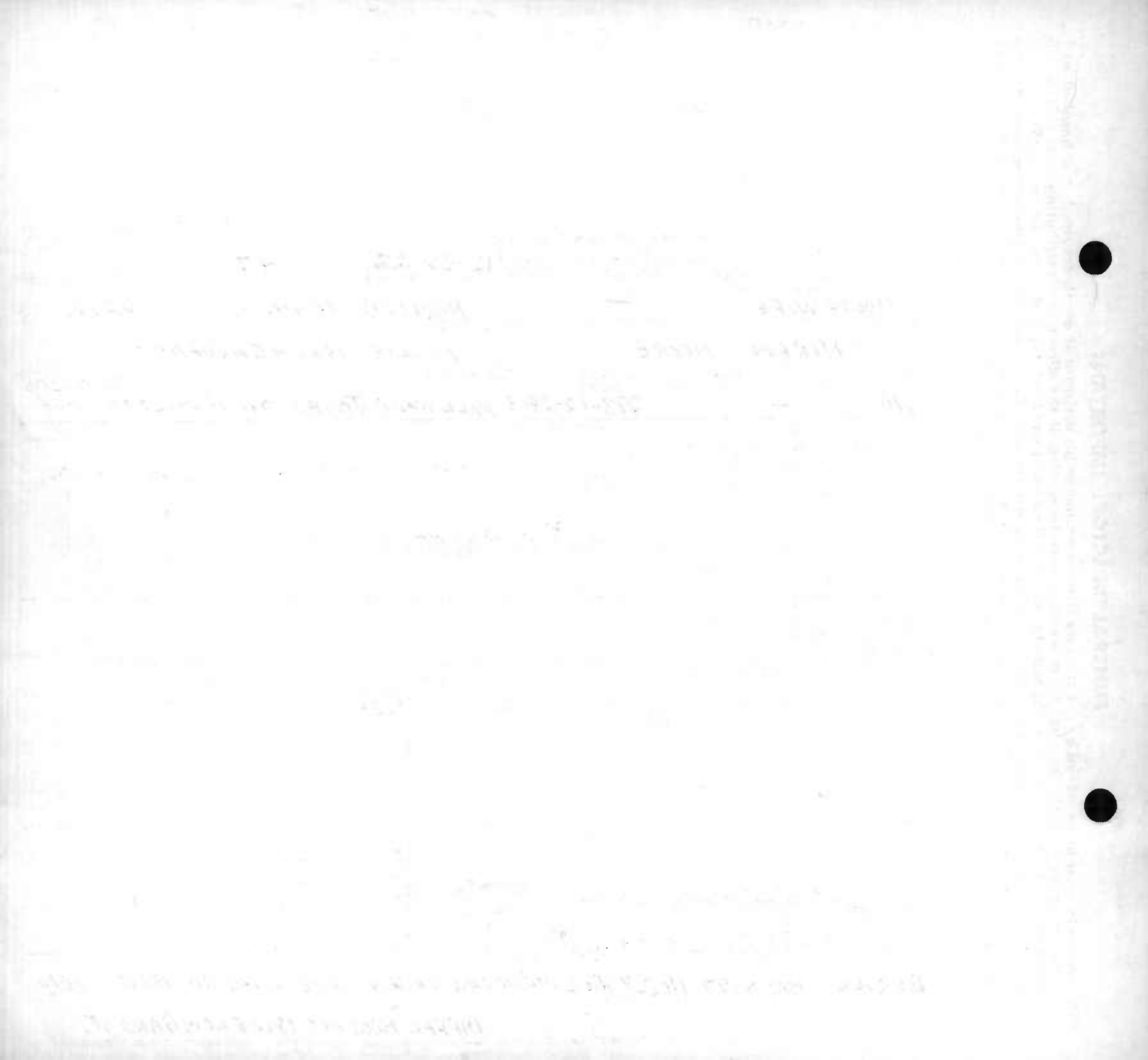
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4340	
BIRTH NO. 71 4340		MILUM		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Dorothy Milum		2. DATE AND HOUR OF DEATH 5/2/71 10:40 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY Balto 702			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital		C. CITY OR TOWN Balto		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10B. KIND OF BUSINESS OR INDUSTRY —		8. DATE OF BIRTH 12-28-23 49	
13. FATHER'S NAME HIREM MOORE		14. MOTHER'S MAIDEN NAME NELLIE BAUMGARDNER		9. AGE (In years last birthday) 47	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 293-12-2813		11. BIRTHPLACE (State or foreign country) HARFORD CONN.	
17. INFORMANT PAUL WADE JONES 711 IV MILTON AVE		ADDRESS 21205		12. CITIZEN OF WHAT COUNTRY U.S.A.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Probable Pulmonary Embolus (B) PERIPHERAL VASCULAR DISEASE (C) DIABETES MELLITUS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs yes yes	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 19 71 to May 2 19 71 that (1) (we) last saw the deceased alive on May 2 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Peter Densen M.D.		23B. DATE SIGNED 5/2/71		23C. PHYSICIAN'S NAME (Type) Peter Densen MD	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE MAY 5 1971		24C. NAME OF CEMETERY OR CREMATORY HOLLY HILL MEMORIAL GARDEN	
25A. DATE REC'D BY HEALTH DEPT. MAY 5 1971		25B. NAME OF REGISTRAR James E. Jones		25C. FUNERAL DIRECTOR DIPPEL BROS INC 1800 E LOMBARD ST.	
24D. LOCATION BALTO MD		24E. LOCATION (City, town, or county) (State)			



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RELEASED ON APPROVAL BY DR. KORNBLUM OF M.F. OFFICE
FUNERAL DIRECTOR: IMPORTANT
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 4341	
BIRTH NO. 71 4341		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) KAREN ROSSBOTTOM		2. DATE AND HOUR OF DEATH MAY 4, 1971 11 35 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 5-13-71		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 1307	
5. SEX F		6. RACE W	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 06-08-44	
9. AGE (in years last birthday) 26		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Receptionist		11. BIRTHPLACE (State or foreign country) Springfield, Ohio	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME BERT A. TEETERS	
14. MOTHER'S MAIDEN NAME KATHERINE KNAPP		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 29-40-7478		17. INFORMANT Mr. Thomas Rossbottom, 500 W. University Parkway	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 3 MAY 3, 1971 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ENCEPHALITIS - BRAIN BIOPSY 20A. AUTOPSY? (Yes or No) YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? 21D. TIME OF INJURY (APPROX.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (1) (this hospital) attended the deceased from 5-1 1971 to 5-4 1971 that (1) (we) last saw the deceased alive on 5-4 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. 23A. SIGNATURE Benjamin L. Portnoy M.D. DEGREE 23B. DATE SIGNED 5-4-71 23C. PHYSICIAN'S NAME (Type) Benjamin Portnoy, M.D. DEGREE 23D. ADDRESS The Johns Hopkins Hospital 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 5/8/71 24C. NAME OF CEMETERY OR CREMATORY First Congregational Church Cemetery 24D. LOCATION (City, town, or county) (State) Old Greenwich, Conn. 25A. DATE REC'D BY HEALTH DEPT. MAY 5 1971 25B. NAME OF REGISTRAR Robert E. Farley M.D. 25C. FUNERAL DIRECTOR Loring-Byers, Funeral Directors P.A. 25D. ADDRESS 8728 Liberty Road, Randallstown, Md.			

THE JAMES H. HARRIS SCHOOL

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5-13-71

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

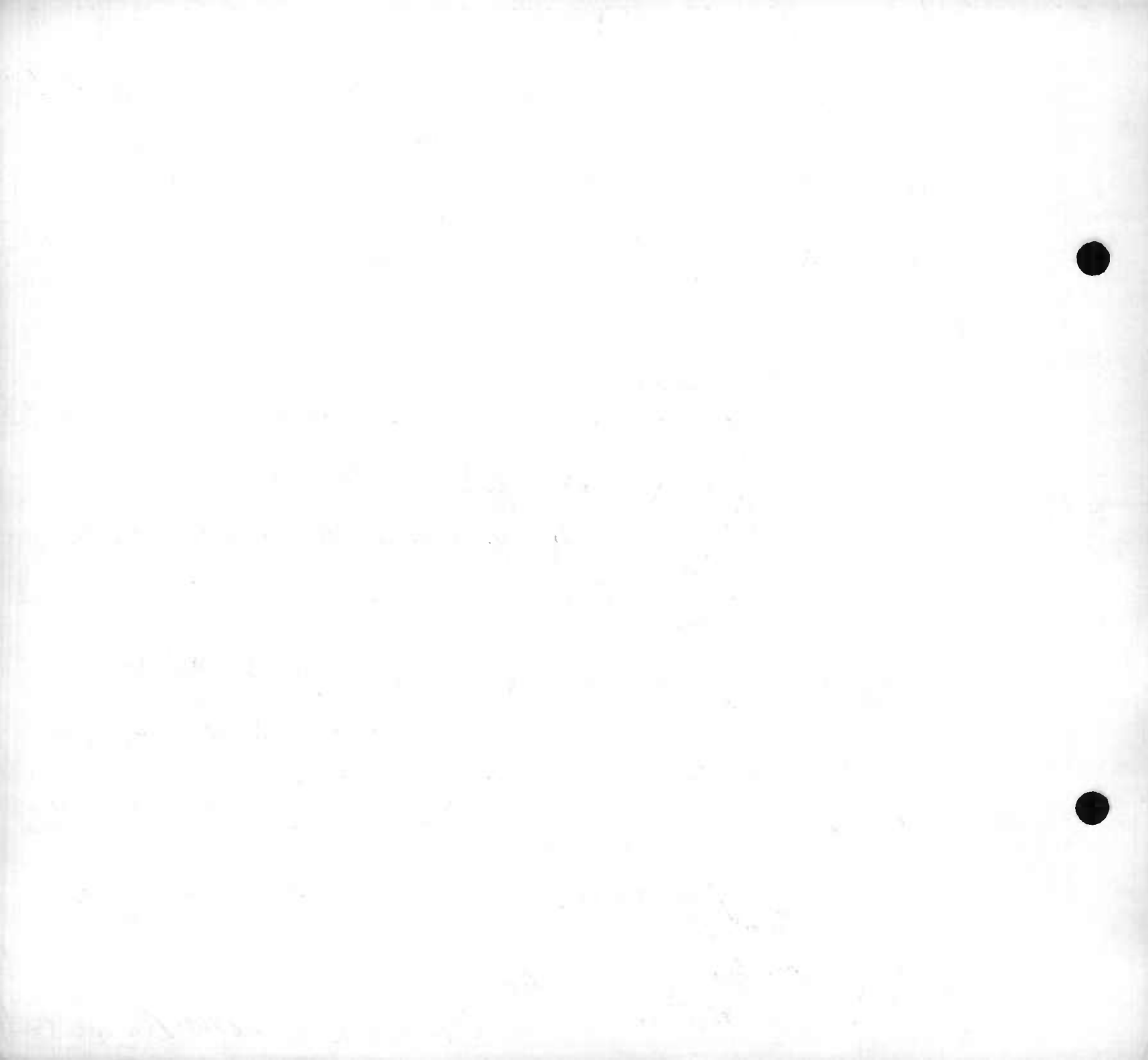
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. [REDACTED]
BIRTH NO. 21 4342		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) James Bond Armstrong		2. DATE AND HOUR OF DEATH May 4, 1971 3 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 00 4209 Eastview Road		A. STATE Maryland 2759		
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 4209 Eastview Road		
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-5-1897	9. AGE (In years last birthday) 73
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Chemist		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.		11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Thomas Armstrong		14. MOTHER'S MAIDEN NAME Elizabeth Bond		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-07-9370-B		17. INFORMANT Mrs. Ruth B. Armstrong
		ADDRESS Same		
18. 441-21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 1 This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH ROPTERED (A) IMMEDIATE CAUSE ABDOMINAL ANEURISM DUE TO, OR AS A CONSEQUENCE OF: ARTERIO-SCLEROSIS (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 HOURS ?
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CHRONIC OBSTRUCTIVE AIRWAY DISEASE		4 YEARS
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from FEBRUARY 1962 to MAY 4, 1971 and that (I) (we) last saw the deceased alive on MAY 4, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Arthur Karfgin		23B. DATE SIGNED 5/5/71		
23C. PHYSICIAN'S NAME (Type) Dr. Arthur Karfgin		23D. ADDRESS 1532 Havenwood Road		
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation	24B. DATE 5-7-71	24C. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	24D. LOCATION (City, town, or county) Baltimore,	(State) Md.
25A. DATE REC'D BY HEALTH DEPT. MAY 5 1971	25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4343	
CERTIFICATE OF DEATH					
BIRTH NO. B-420 71 4343					
1. NAME OF DECEASED (Type or Print) SYLVESTER		2. DATE AND HOUR OF DEATH 4 MAY 1971 11 35 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 38 UNIVERSITY HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 21201 2101			
FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIVERSITY HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M		6. RACE N		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 24 MAY 1910		9. AGE (in years last birthday) 60		10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WAYMAN Black		14. MOTHER'S MAIDEN NAME Mattie Black	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 245-03-8313		17. INFORMANT James S. Black 4212 IVANHOE AVE.	
18. E8901		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Renal Failure DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Third degree burn 90% of body DUE TO, OR AS A CONSEQUENCE OF: 72 hr			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 1 May 71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Strangulation Exchance		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 765 W Pratt St, Balt, Md	
21D. TIME OF INJURY (APPROX.) May 1, '71 7:40 P		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fire	
22. I certify that (he) (this hospital) attended the deceased from 1 May 19 71 to 4 May 19 71 that (he) (we) last saw the deceased alive on 4 May 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Gregory Brown				23B. DATE SIGNED 4 May '71	
23C. PHYSICIAN'S NAME (Typo) Robert E. Fisher, M.D.				23D. ADDRESS 661 W. Barre St	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/7/71		24C. NAME of CEMETERY or CREMATORY Mt Auburn	
24D. LOCATION Baltimore, Md		25A. DATE REC'D BY HEALTH DEPT. MAY 5 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Charles A. Rice		25D. ADDRESS 661 W. Barre St			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 4344

BIRTH NO.

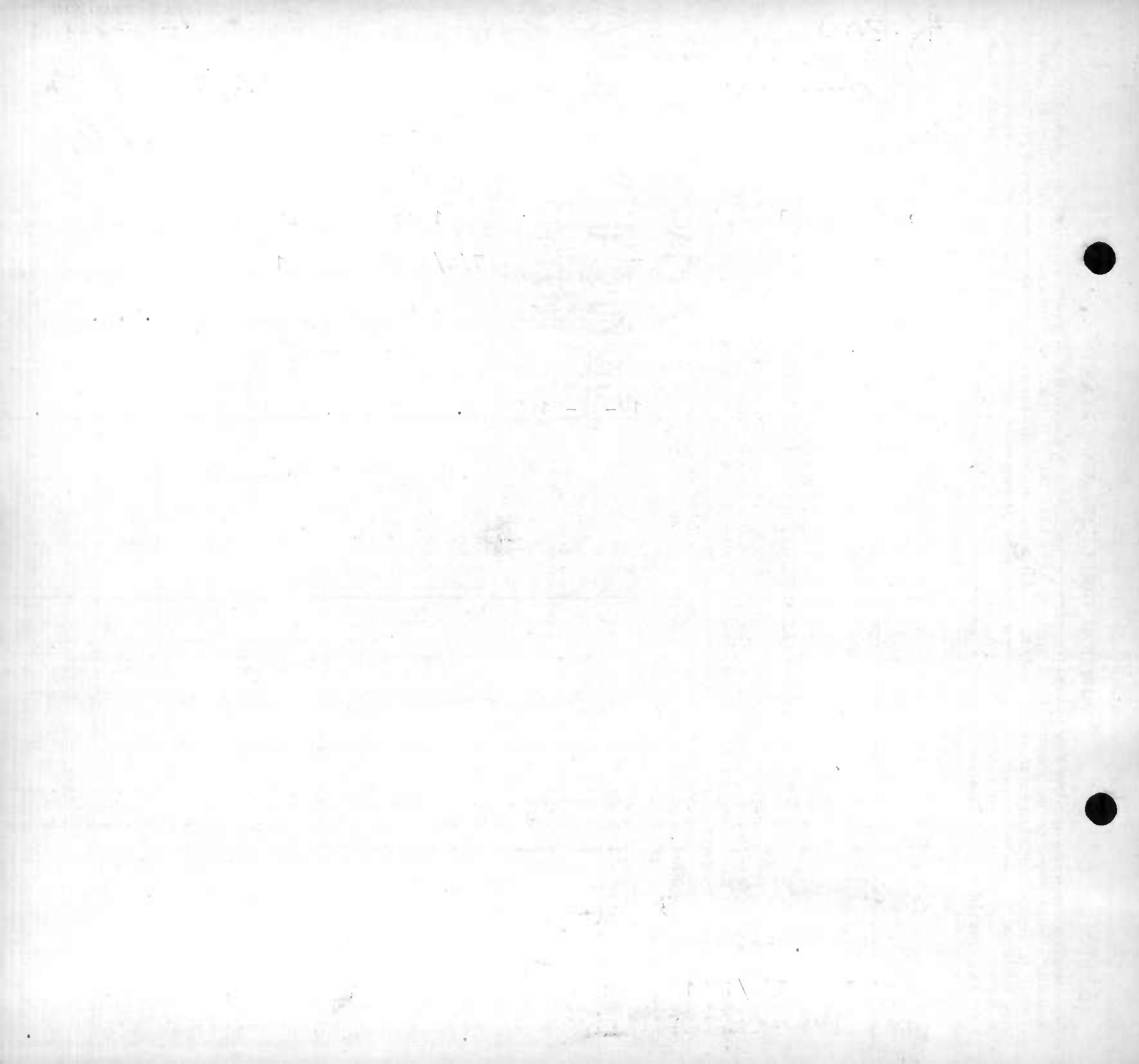
1. NAME OF DECEASED (Type or Print) JOSEPHINE HAYES		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 5 2 1971 7 p	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3023 E. LaRue Square		3. DATE PRONOUNCED DEAD Month Day Year Hour 5 2 1971 7 p	
6. SEX female		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 3/4/95		10. AGE (in years lost birthday) 76	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unemployed		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Versella Lettou		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
17. SOCIAL SECURITY NO. 215-18-9763A		18. INFORMANT Douglas Steadman	
19. CAUSE OF DEATH Arteriosclerotic cardiovascular disease		ADDRESS 2252 Madison Ave.	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Isidore Mihalakis</i> M.D. EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED 5/3/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/6/71	
24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Pk.		24D. LOCATION (City, town, or county) (State) Arbutus, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 5 1971		25B. NAME OF REGISTRAR Robert E. Fisher, Md.	
25C. FUNERAL DIRECTOR Charles A. Rice		ADDRESS 661 W. Barre St.	

WALTER H. BROWN
207-100-1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

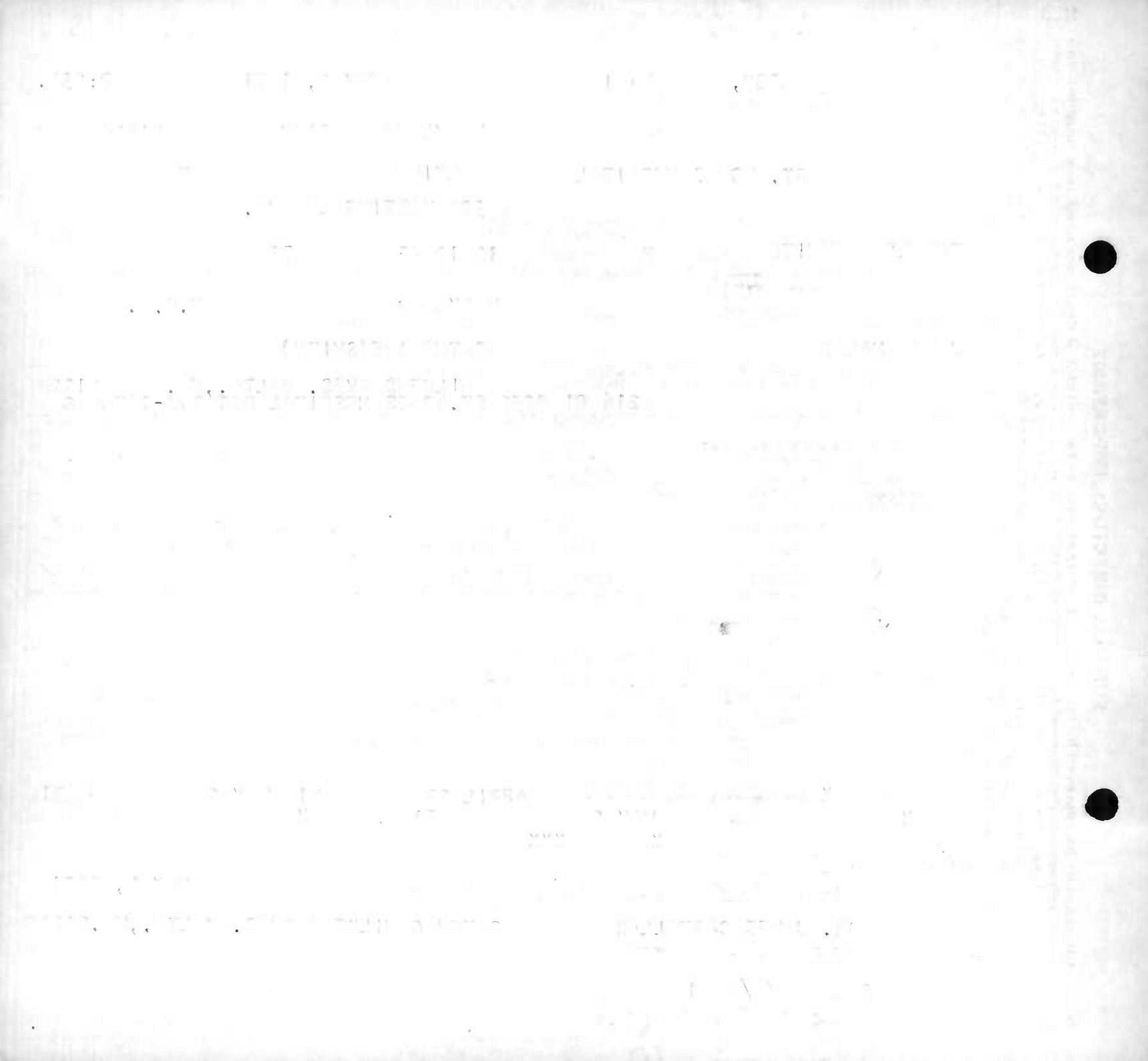
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4345	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) ALICE MEADOWS RUTH		2. DATE AND HOUR OF DEATH 5/1/71 8:15 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 90 Gould Convalesarium		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1401 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 301 McMechen Street			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/1/1889	9. AGE (In years lost birthday) 81	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10B. KIND OF BUSINESS OR INDUSTRY Public Schools		11. BIRTHPLACE (State or foreign country) Kentucky	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Joseph Meadows			
14. MOTHER'S MAIDEN NAME Bell Fuller		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 212-05-9167		17. INFORMANT Mr. Charles W. Ruth 2909 Andorra Ct.			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE Acute Cerebral Thrombosis DUE TO, OR AS A CONSEQUENCE OF: (B) Arteriosclerotic Cerebrovascular Disease DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 3 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Chronic Brain Syndrome; Vertigo; unsteady gait					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/21/1970 to 5/1/1971 , that (I) (we) lost 4/30/1971 and that in (my) (our) opinion death occurred on the date 5/1/1971 and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Albert B. Bradley				23B. DATE SIGNED 5/1/71	
23C. PHYSICIAN'S NAME (Type) Albert B. Bradley		23D. ADDRESS 4900 Belair Road			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/4/1971		24C. NAME OF CEMETERY OR CREMATORY Loudon Park	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. MAY 5 1971			
25B. NAME OF FUNERAL DIRECTOR G. Truman Schwab		25C. ADDRESS 3512 Frederick Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

HBD M-250 71 4346				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 4346		
1. NAME OF DECEASED (Type or Print) MASON, ANNA MARIE				2. DATE AND HOUR OF DEATH MAY 2, 1971 7:03A						
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY CITY 21229 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 332 MARTINGALE AVE. 2541						
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 13 97	9. AGE (in years last birthday) 73	If Under 1 Yr. Months: Days: Hours: Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOHN WHALEN				14. MOTHER'S MAIDEN NAME CATHERINE (SMITH)						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 216 01 0552		17. INFORMANT WILKENS AVES. BALTO. MD. 21229 ST. AGNES HOSPITAL RECORDS-CATON &				ADDRESS	
18. 1820 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarct (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 3 days ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Abdominal Hysterectomy 3 days Endometrial Carcinoma Unknown				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).										
19A. DATE OF OPERATION 4-29-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ENDOMETRIAL CARCINOMA		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from APRIL 27 19 71 to MAY 2 19 71 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MAY 2 19 71 and that <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.										
23A. SIGNATURE Dr. James Castellano, MD				23B. DATE SIGNED MAY 2, 1971		23C. PHYSICIAN'S NAME (Type) DR. JAMES CASTELLANO				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 5/5/1971		24C. NAME of CEMETERY or CREMATORY Loudon Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. MAY 5 1971				25B. NAME OF REGISTRAR G. Truman Schwab, MD		25C. FUNERAL DIRECTOR ADDRESS G. Truman Schwab 3512 Frederick Ave.				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

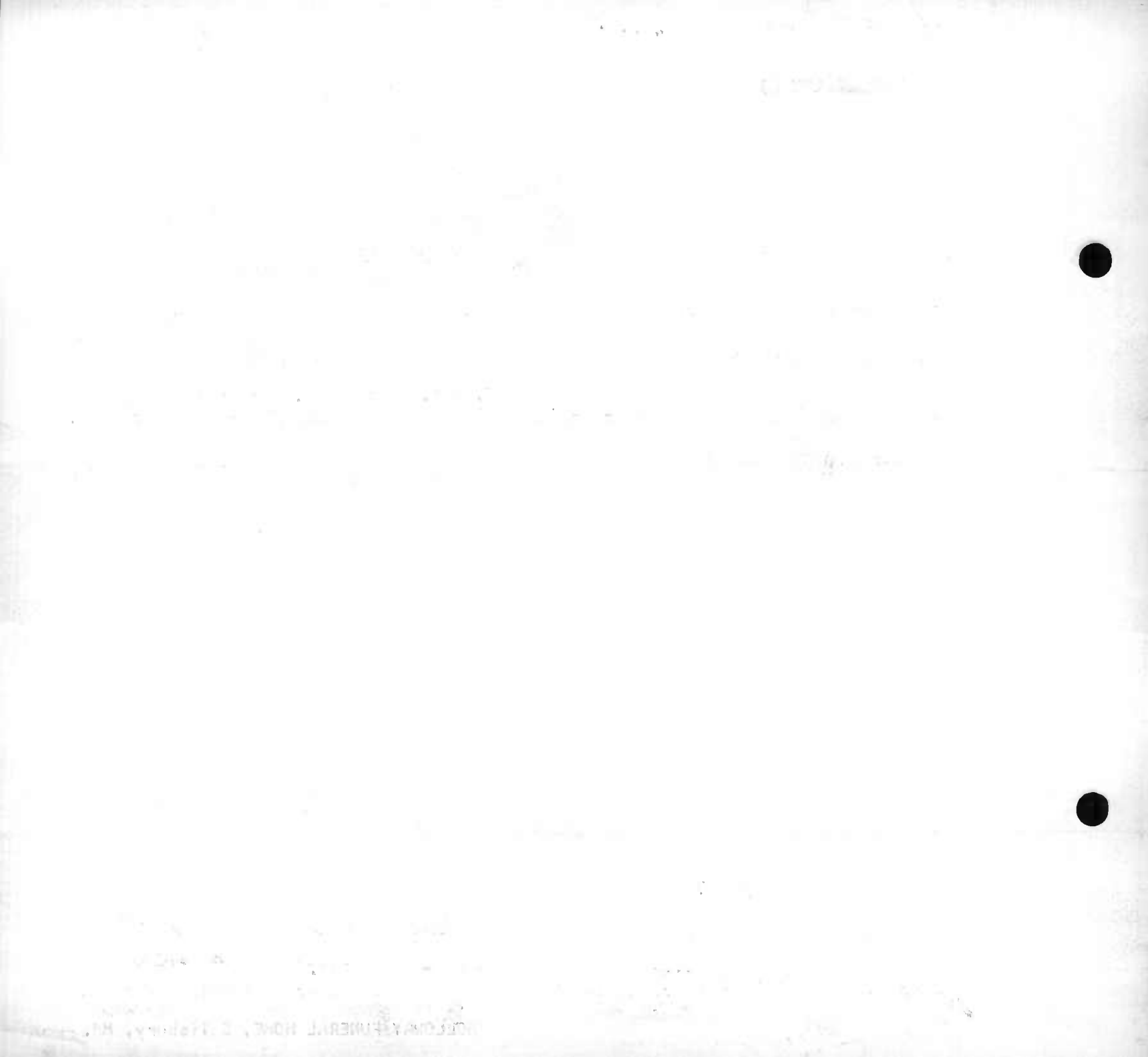
BALTIMORE CITY HEALTH DEPARTMENT				71 4347	
CERTIFICATE OF DEATH				REG. NO. 71 4347	
BIRTH NO. L-563					
1. NAME OF DECEASED (Type or Print) Mary LaMartina		2. DATE AND HOUR OF DEATH 27 April 1971 4:00 P			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 823 So. Milton Avenue		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 104 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 823 So. Milton Avenue			
5. SEX female	6. RACE caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 30 Sept. 1907	9. AGE (In years last birthday) 63	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Michael Gibula		14. MOTHER'S MAIDEN NAME Magdalen Witkowicz			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213 16 3569		17. INFORMANT ADDRESS Salvatore LaMartina 8909 Parlo Rd. 21236	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 412.41 + 250.9 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Arteriosclerotic C.V. Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Unknown	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Diabetes Mellitus		Unknown	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9/5 19 68 to 4/27 19 71 that (I) (we) last saw the deceased alive on 4/27 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Henry J. Houska M.D.		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) HENRY J. HOUSKA M.D.	
23D. ADDRESS 333 S. EAST AVE BALTO MD		23E. DATE REC'D BY HEALTH DEPT. MAY 5 1971			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 30 Apr. 71		24C. NAME OF CEMETERY OR CREMATORY Oaklawn	
24D. LOCATION (City, town, or county) (State) Baltimore Ct. Maryland		25. FUNERAL DIRECTOR ADDRESS Raymond L. Kaczorowski 2525 Fleet Street			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4348	
H-652 71 4348		CERTIFICATE OF DEATH			
1. NAME OF DECEASED LAWRENCE WESLEY (Dick) HARRINGTON		2. DATE AND HOUR OF DEATH 4/29/71 8:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Bolton Hill Nursing Home		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 602			
5. SEX male		6. RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 9-8-08		9. AGE (In years last birthday) 62 yrs.		10. UNDER 1 Yr. Months: Days: 11. UNDER 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tile Setter		10B. KIND OF BUSINESS OR INDUSTRY Tile		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME John Wesley Harrington		14. MOTHER'S MAIDEN NAME Janie Elsie Brown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 212-12-3913		17. INFORMANT T. Sgt. Lawrence R. Harrington (Son) Admission Record Salisbury, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE Pneumonia CA with DUE TO, OR AS A CONSEQUENCE OF: relaxation (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9/70			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/5 19 71 to 4/29 19 71 that (I) (we) last saw the deceased alive on 4/29 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED 4/30/71	
23C. PHYSICIAN'S NAME (Type) ALAN H. MARRAS MD				23D. ADDRESS 2 E. Polk St. Baltimore 21202	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/4/71		24C. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	
24D. LOCATION (City, town, or county) Salisbury, Wicomico, Maryland		24E. IS TOL			
25A. DATE REC'D BY HEALTH DEPT. MAY 5 1971		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR HOLLOWAY FUNERAL HOME, Salisbury, Md.	



S-363

71 4348

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 4348

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LEWIS A. STEWART

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00 4402 Wrenwood Avenue

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

April 23, 1971

4:50 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

2710

6. SEX

Male

7. RACE

Negro

B. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

10. AGE (In years
last birthday) 90If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

4402 Wrenwood Avenue

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

19. 412.4 I
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH
(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S NAME (Type) Werner U. Spitz, M.D.

M.D.

Deputy CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

5-4-71

24C. NAME OF CEMETERY

ANATOMY BOARD OF MARYLAND

UNIVERSITY MEDICAL SCHOOL

MORTUARY SERVICE - BCHD

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

MAY 5 1971

191

17

[Handwritten signature]

RECEIVED
JAN 10 1917
U.S. DEPT. OF JUSTICE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 4350

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

RODGER BEY

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If not in hospital or institution, give street
address or location)3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

April 26, 1971

10:35 PM

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

10. AGE (In years
lost birthday)

85

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

903 W. Saratoga Street

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

19.

41271

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

5-4-71

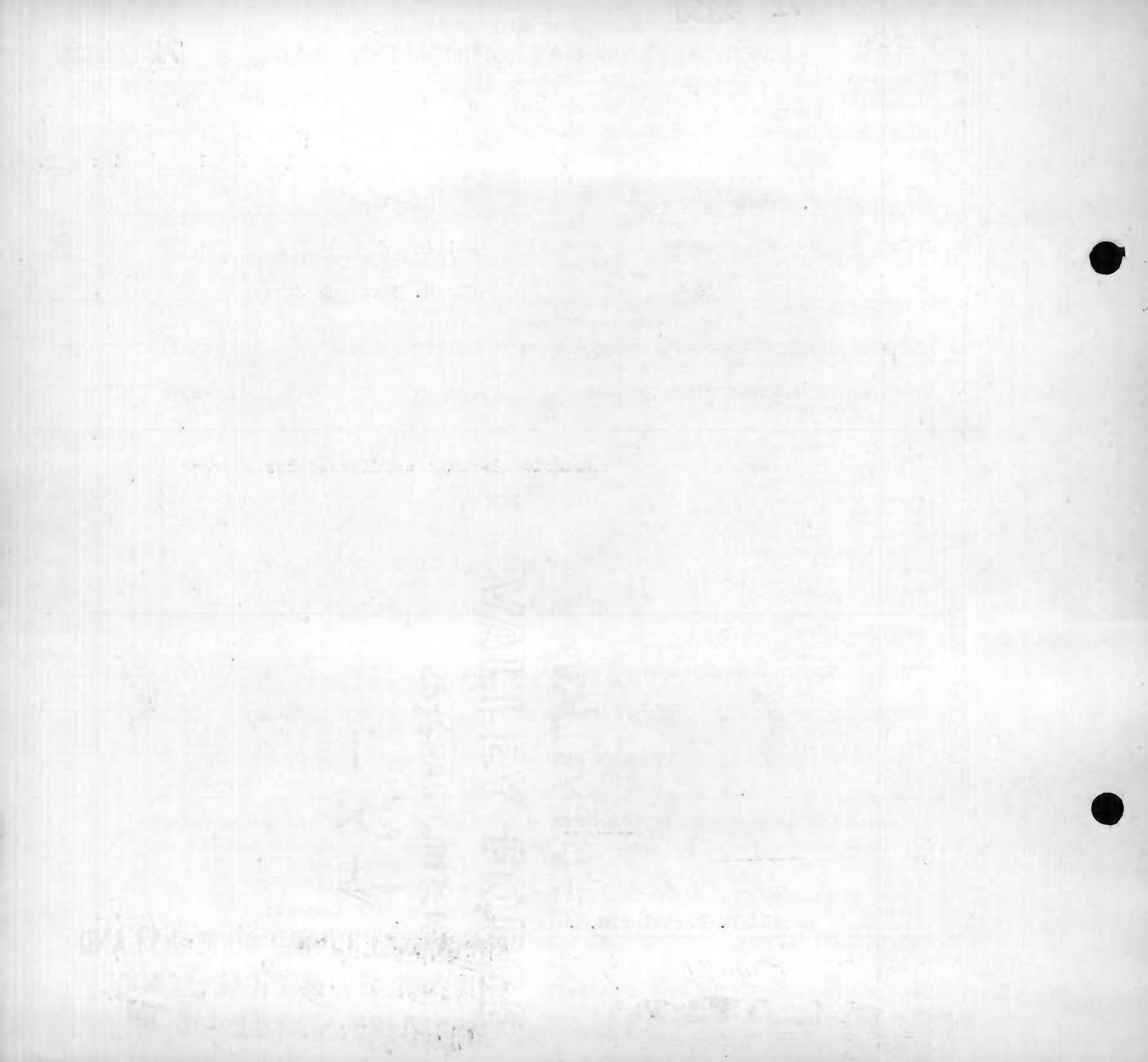
24C. NAME of CEMETERY or CREMATOR (If in Baltimore City, give exact location)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

MAY 5 1971 Robert E. Kelly, M.D.

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
FUNERAL DIRECTOR
MORTUARY SERVICE - BCHO



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 4351

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARY DAVIS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1719 Division Street		3. DATE PRONOUNCED DEAD Month Day Year Hour April 23, 1971 11:15 P.	
6. SEX Female		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE Negro		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 74		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years lost birthday) 74		E. STREET AND NUMBER 1719 Division Street	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		CAUSE OF DEATH Arteriosclerotic cardiovascular disease	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. EXAMINER'S NAME (Type) DATE SIGNED 4/24/71			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 5-4-71	
24C. NAME OF CEMETERY		24D. NAME OF REGISTRAR	
25A. DATE REC'D BY HEALTH DEPT. MAY 5 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCHD

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THE UNIVERSITY OF MICHIGAN

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71 4352 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 4352

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Bessie Watkins

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

00

1111 Carson Court

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

5

4

71

4:40 a.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

1601

6. SEX

female

7. RACE

colored

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

5-28-01

10. AGE (In years
last birthday)

69

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1111 Carson Ct.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Thomas F. Fenwick

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Mary E. Mahoney

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

218-22-7492

18. INFORMANT

ADDRESS

Mr. Avon Watkins 1111 Carson Court

19. 412.4

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (if in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

Deputy Chief Medical Examiner

DATE SIGNED

5/4/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

5-7-71

24C. NAME of CEMETERY or CREMATORY

Mt Auburn Cemetery

24D. LOCATION (City, town, or county) (State)

Balto., Md.

25A. DATE REC'D BY HEALTH DEPT.

MAY 5 1971

25B. NAME OF REGISTRAR

Robert E. J. J. J. J.

25C. FUNERAL DIRECTOR

Wm C March 928 E. North Ave.

71 4353

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 4353

BIRTH NO.

1. NAME OF DECEASED

(Johnnie) John Thomas

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Maryland General Hospital

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

5/4/71

5:00 a.m.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

male

7. RACE

colored

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

6-2-30

10. AGE (In years
last birthday)

40

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

415 E. Chase St.

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Sallie Thomas

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Mr. Ozell Wright 419 E. Chase Street

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)Smoke and soot inhalation incidental to
(A) IMMEDIATE CAUSE conflagration
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)
no22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)
house22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

2155 Lafayette Ave. 1605

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.) 5 4 71 3:50 a. m.22E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

housefire

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

EXAMINER'S

NAME (Type) Werner U. Spitz, M.D.

Deputy Chief Medical Examiner

5/4/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

5-7-71

24C. NAME OF CEMETERY or CREMATORY

Mt Auburn Cemetery

24D. LOCATION (City, town, or county)

Balto., Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAY 5 1971

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Wm C March 928 E. North Ave.

ADDRESS

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71 4354

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

71 4354

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

CARL E. OLSZEWSKI

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF
HOSPITAL
OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

35 CHURCH HOME AND HOSPITAL

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

May 4, 1971

9:00 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

1204

6. SEX

Male

7. RACE

White

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐SEPERATED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

May 11, 1928

10. AGE (In years
last birthday)

42

If Under 1 Yr. II Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

306 East North Avenue

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Anthony Olszewski

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Seaman

14B. KIND OF BUSINESS OR INDUSTRY

Maritime

15. MOTHER'S MAIDEN NAME

Mary Zaniewski

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

11/21/51 to

17. SOCIAL
SECURITY NO.

219-22-0965

18. INFORMANT

ADDRESS

#21224

Mrs. Frances Scitinski - 324 Folcroft St.

19. 57181 11/20/53

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

Fatty metamorphosis of liver

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES
DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/5/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

5/7/71

24C. NAME of CEMETERY or CREMATORY

Catholic Cem.

Holy Cross Polish National

24D. LOCATION

(City, town, or county)

(State)

Baltimore County, Md.

25A. DATE REC'D BY HEALTH DEPT.

MAY 6 1971

25B. NAME OF REGISTRAR

Robert E. Kelley, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

George A. Weber - 705 S. Ann St. #21231

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WALTERS

104

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

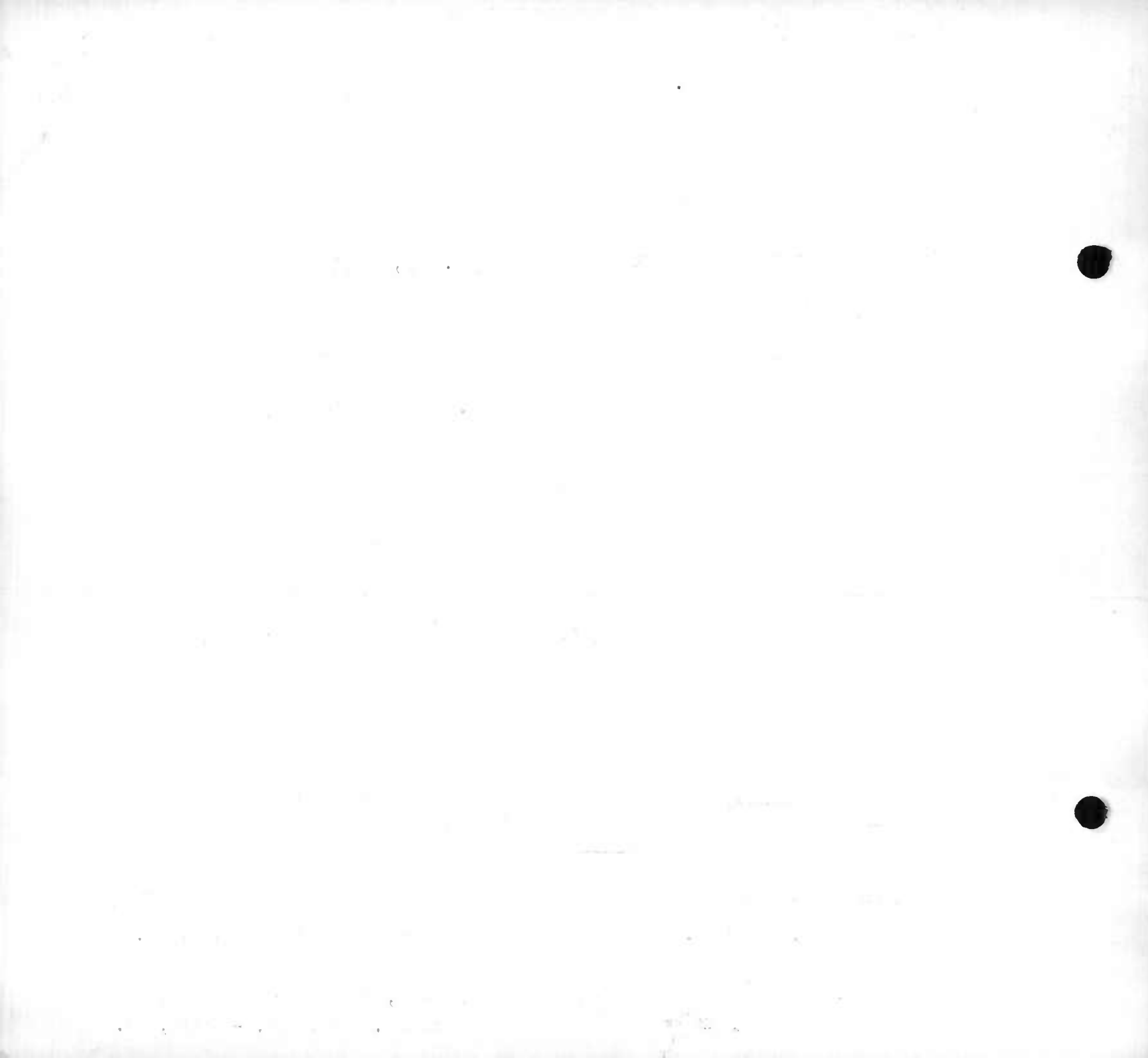
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71-4355</u>
BIRTH NO. <u>G-163</u>		71 4355		
1. NAME OF DECEASED (Type or Print) <u>ADDIE E. GIFFORD</u>		2. DATE AND HOUR OF DEATH <u>May 4, 1971</u> <u>1.05</u> a. m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2744</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00 5606 Carter Avenue</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <u>female</u> 6. RACE <u>caucasian</u>		E. STREET AND NUMBER <u>5606 Carter Avenue</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 1, 1887</u> 9. AGE (In years last birthday) <u>83</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Henry Groshans</u>		14. MOTHER'S MAIDEN NAME <u>Addie Sophia Tauber</u>		
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-22-7204</u>		
		17. INFORMANT <u>Mr R. Hugh Gifford</u> ADDRESS <u>Kingsville Md</u>		
18. <u>412.31</u> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>Coronary Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>4-13</u> 19 <u>71</u> to <u>April 29</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>4-29</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Dr. Sebastian Russo</u>		23B. DATE SIGNED <u>5-4-71</u>		
23C. PHYSICIAN'S NAME (Type) <u>Dr. Sebastian Russo</u>		23D. ADDRESS <u>5017 Harford Rd, Balto, Md.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>5/6/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Greenmount</u>
24D. LOCATION (City, town, or county) <u>Baltimore, Md.</u>		(State)		
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 6 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Tucker, M.D.</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. - Balto, Md. - 14</u>
ADDRESS				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

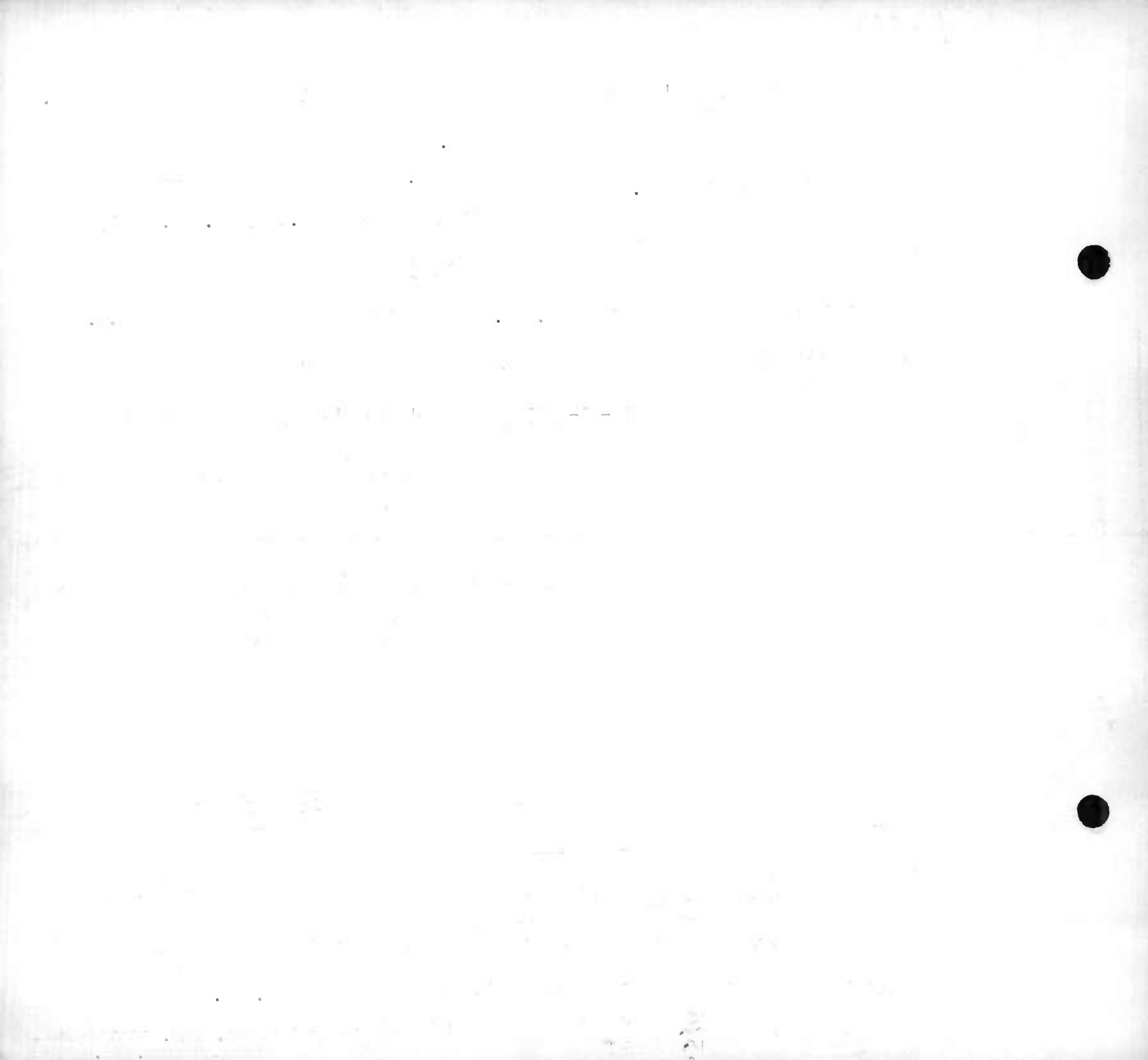
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 4356</u>
P-423 <u>71 4356</u>		BIRTH NO.		
1. NAME OF DECEASED (Type or Print) <u>EMMA B. PULKETT</u>		2. DATE AND HOUR OF DEATH <u>May 3, 1971</u> <u>10:30 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2743</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>90 HOUSE IN THE PINES BELAIRE</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>5108 Holder Avenue</u>		
5. SEX <u>female</u>	6. RACE <u>caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 25, 1887</u>	9. AGE (In years last birthday) <u>94</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13. FATHER'S NAME <u>Frank Goldsmith</u>		
14. MOTHER'S MAIDEN NAME <u>Katherine Stezka</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service] <u>No</u>		
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Wilbur Pulkett</u>		
ADDRESS <u>Same</u>				
18. <u>4123 I</u> CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>Acute Peripheral Circulatory Failure</u> DUE TO, OR AS A CONSEQUENCE OF:		
		(B) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF: <u>years</u>		
		(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Chronic Diverticulosis Perforated Sigmoid Colon</u> <u>years</u>				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>4/19/67</u> to <u>5/3/71</u> that (I) (we) last saw the deceased alive on <u>5/3/1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.				
23A. SIGNATURE <u>Albert B. Bradley</u>		23B. DATE SIGNED <u>5/14/71</u>		
23C. PHYSICIAN'S NAME (Type) <u>Dr. Albert B. Bradley</u>		23D. ADDRESS <u>4900 Belair Rd, Balto, Md.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/7/71</u>		24C. NAME of CEMETERY or CREMATORY <u>Most Holy Redeemer Cem, Baltimore Maryland</u>
24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 6 1971</u>		
25B. NAME OF REGISTRAR <u>John R. Ruck</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. - Balto, Md.</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 4357
D-520 71 4357				
BIRTH NO.		2 A. M.		
1. NAME OF DECEASED (Type or Print) Domenico D'Amico		2. DATE AND HOUR OF DEATH 5/4/71		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 00 3311 Lawnview Ave.		A. STATE Md. B. COUNTY 2643		
		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 3311 Lawnview Ave., Balto. Md. 21213		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/22/83	9. AGE (in years last birthday) 88
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cement finisher		10B. KIND OF BUSINESS OR INDUSTRY Picarelli Const. Co.		11. BIRTHPLACE (State or foreign country) Italy
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 214-01-2011		17. INFORMANT Anna D'Amico (wife)
				ADDRESS same address
18. 410.91 CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Coronary Thrombosis				Instantaneous
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic C. V. Disease				10 years
(B) Generalized Arteriosclerosis				Unknown
(C) Asthmatic Bronchitis				15 years
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 5/4		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 4/9/71 to 5/4/71 that (I) (we) last saw the deceased alive on 5/4/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE Henry J. Houska MD		23B. DATE SIGNED 5/4/71		23C. PHYSICIAN'S NAME (Type) HENRY J. HOUSKA MD
		23D. ADDRESS 333 S. EAST AVE BALTO MD		
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 5/7/71		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery
				24D. LOCATION (City, town, or county) (State) Balto. Md.
25A. DATE REC'D BY HEALTH DEPT. MAY 6 1971		25B. NAME OF REGISTRAR Robert J. Miller		25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

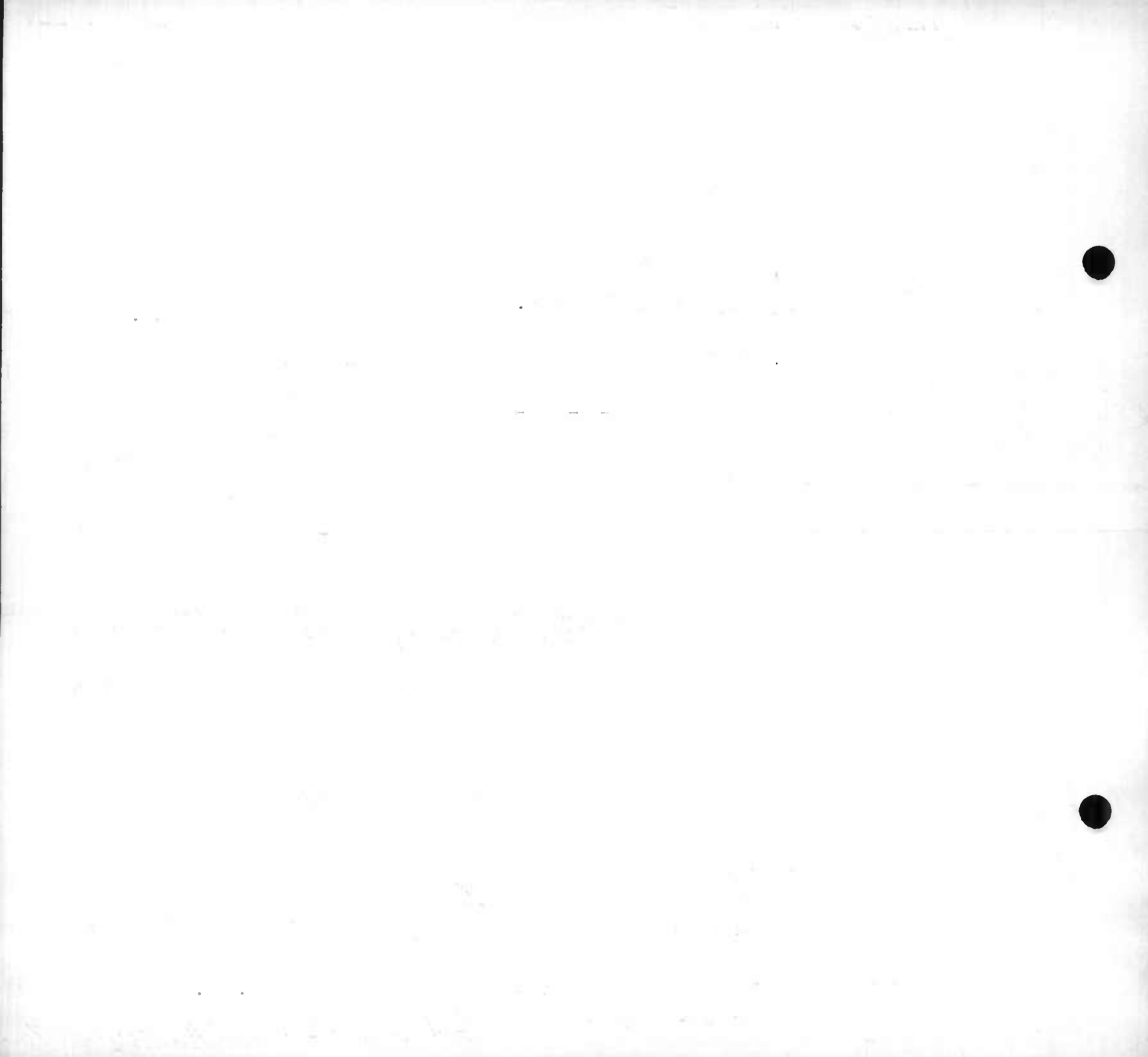
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
71 4358		71 4358		71 4358	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Nellie Palechek		5/2/71 12:15 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital, Inc.		A. STATE Maryland		B. COUNTY 2633	
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 9/9/04	
13. FATHER'S NAME Melvin S. Coates		14. MOTHER'S MAIDEN NAME Ida Hynson		9. AGE (In years lost birthday) 66	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 220-05-0785		10. CITIZEN OF WHAT COUNTRY? USA	
17. INFORMANT Joseph Palechek, Son, 2220 Hamilton Town		ADDRESS Circle			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. If means the disease, injury or complication which caused death.) 410.91 + 250.9 Acute Myocardial Infarction		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary Insufficiency		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: Atherosclerosis		(C) Diabetes Mellitus	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 1, 1971 to May 1, 1971 that (I) (we) last saw the deceased alive on 5/1/71 3:00 pm 1971 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE G. Mijares M.D.		23B. DATE SIGNED May 2, 1971			
23C. PHYSICIAN'S NAME (Type) G. MIJARES, M.D.		23D. ADDRESS MERCY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 5/5/71		24C. NAME OF CEMETERY OR CREMATORY Meddowridge Cemetery	
24D. LOCATION Baltimore, Maryland		24E. NAME OF REGISTRAR Robert E. Fisher, M.D.		24F. FUNERAL DIRECTOR Schmunch Funeral Home 3331 Bickham Lane	
25A. DATE REC'D BY HEALTH DEPT. MAY 6 1971		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	



FUNERAL DIRECTOR: IMPORTANT

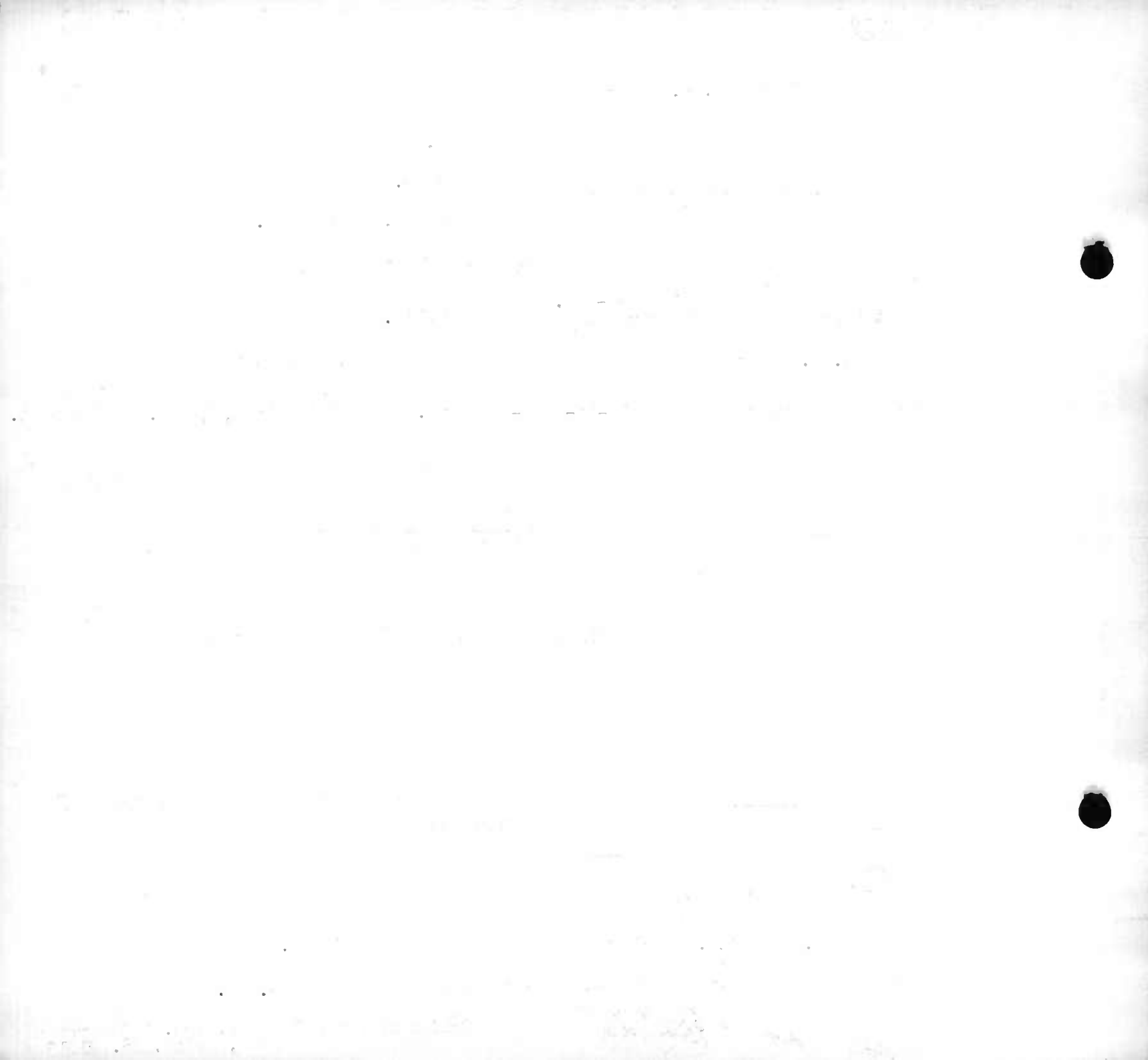
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 71 4358	
1. NAME OF DECEASED (Type or Print) JOSEPH C. DRIMAL				2. DATE AND HOUR OF DEATH 5/3/71 12²⁰ PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD MD. GENERAL HOSP.				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) MD. 21222 5300			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MD. GENERAL HOSP.				C. CITY OR TOWN BALTO		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 7703 BATTLE GROVE RD.			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-10-98	9. AGE (in years last birthday) 72	10. Under 1 Yr. Months	11. Under 24 Hrs. Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED mechanic				10B. KIND OF BUSINESS OR INDUSTRY Monumental Bus Co.		11. BIRTHPLACE (State or foreign country) BALTO, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.				13. FATHER'S NAME Joseph F. Drimal			
14. MOTHER'S MAIDEN NAME Anna Hlavin				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. 218-07-7780-4				17. INFORMANT MARIE DI CLEMENTI			
18. CAUSE OF DEATH Cardiac arrest during surgery				ADDRESS 3402 E. FAIRMOUNT AVE. BALTO #21222			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac arrest during surgery				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH mins			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Ischemic Heart Disease				DUE TO, OR AS A CONSEQUENCE OF: 4 yrs			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Prior bronchogenic carcinoma				DUE TO, OR AS A CONSEQUENCE OF: WKS			
19A. DATE OF OPERATION 5/3/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED bronchogenic ca		20A. AUTOPSY (Yes or No) (yes)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (yes)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		21C. WHERE DID INJURY OCCUR? home		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 4/8 1971		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? 4/8 1971 to 5/3 1971			
22. I certify that (I) (this hospital) attended the deceased from 4/8 1971 to 5/3 1971 that (I) (we) last saw the deceased alive on 5/3 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE A. N. MAVRIDIS M.D.				23B. DATE SIGNED 5/3/71		23C. PHYSICIAN'S NAME (Type) A. N. MAVRIDIS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 5/7/71		24C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 6 1971		25B. NAME OF REGISTRAR Robert E. Jones, R.D.		25C. FUNERAL DIRECTOR Schumacher Funeral Home		ADDRESS 5330 Balto. Ave.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

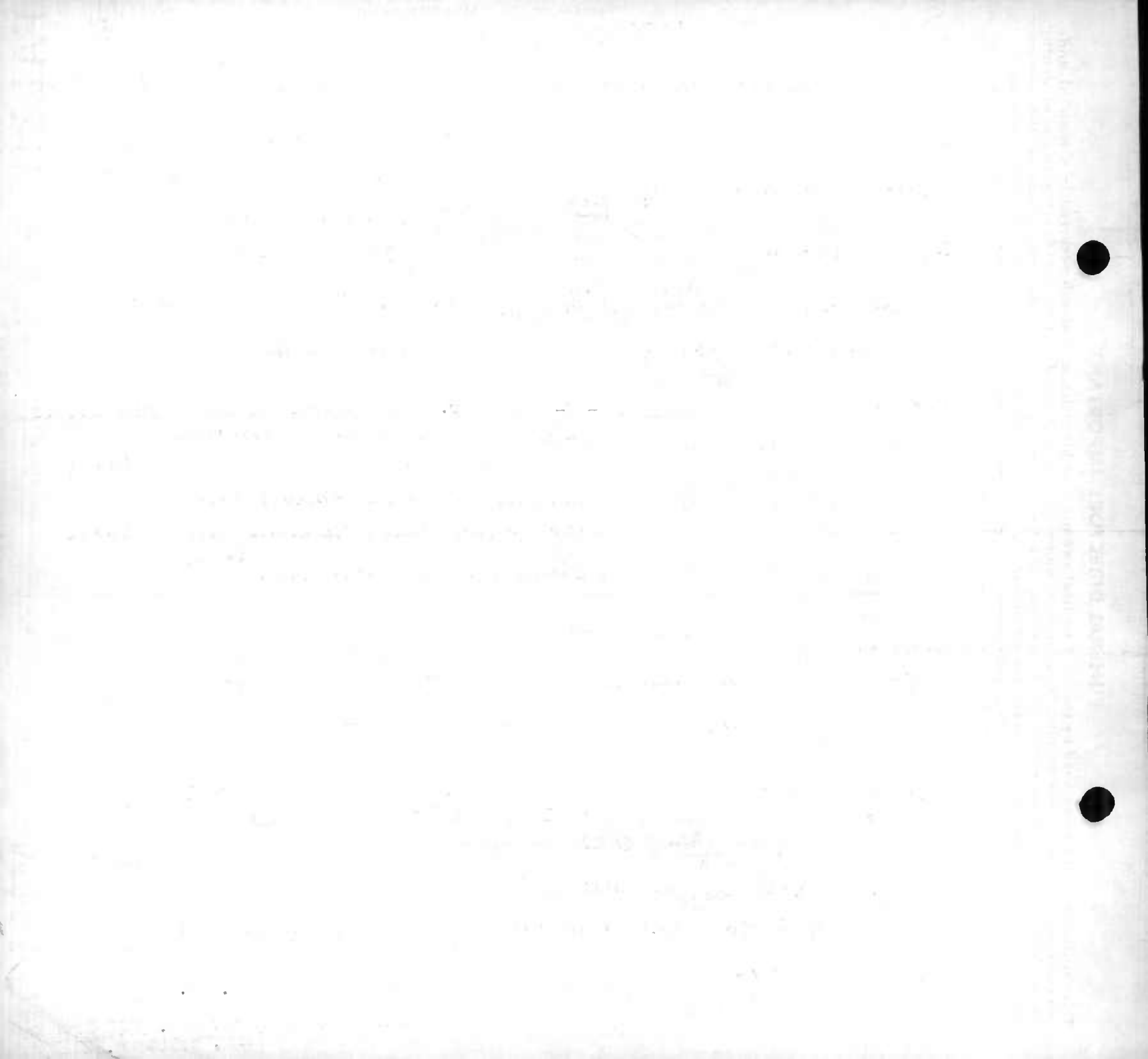
A-352		71 4360		BALTIMORE CITY HEALTH DEPARTMENT		71 4360	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) Michael J. J. Adams				2. DATE AND HOUR OF DEATH 5/2/77 8 ⁴⁵ A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Gould Convalescent Home				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Md. B. COUNTY 702			
5. SEX M		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 2/13/1901	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) bartender		10B. KIND OF BUSINESS OR INDUSTRY Crimmons - Md. Pleasure Club		11. BIRTHPLACE (State or foreign country) Balto.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Robt. A. Adams				14. MOTHER'S MAIDEN NAME Emma Marshall			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW I		16. SOCIAL SECURITY NO. 212-32-4185-A		17. INFORMANT (sister) Mrs. Catherine Shiner, 320 N. Robinson St. ADDRESS 21224			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) HEPATIC COMA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Circumstances of the Death II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Pneumonia, Chronic Brain Symp, Arteriosclerosis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days year			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/12/77 1977 to 5/2/77 1977 that (I) (we) last saw the deceased alive on 5/1/77 1977 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Albert B. Bradley				23B. DATE SIGNED 5/3/77		23C. PHYSICIAN'S NAME (Type) Dr. Albert B. Bradley	
24A. BURIAL CREMATION, REMOVAL (Specify) burial				24B. DATE 5/6/77		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	
25A. DATE REC'D BY HEALTH DEPT. MAY 6 1977				25B. NAME OF REGISTRAR Robert E. Adams, M.D.		25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

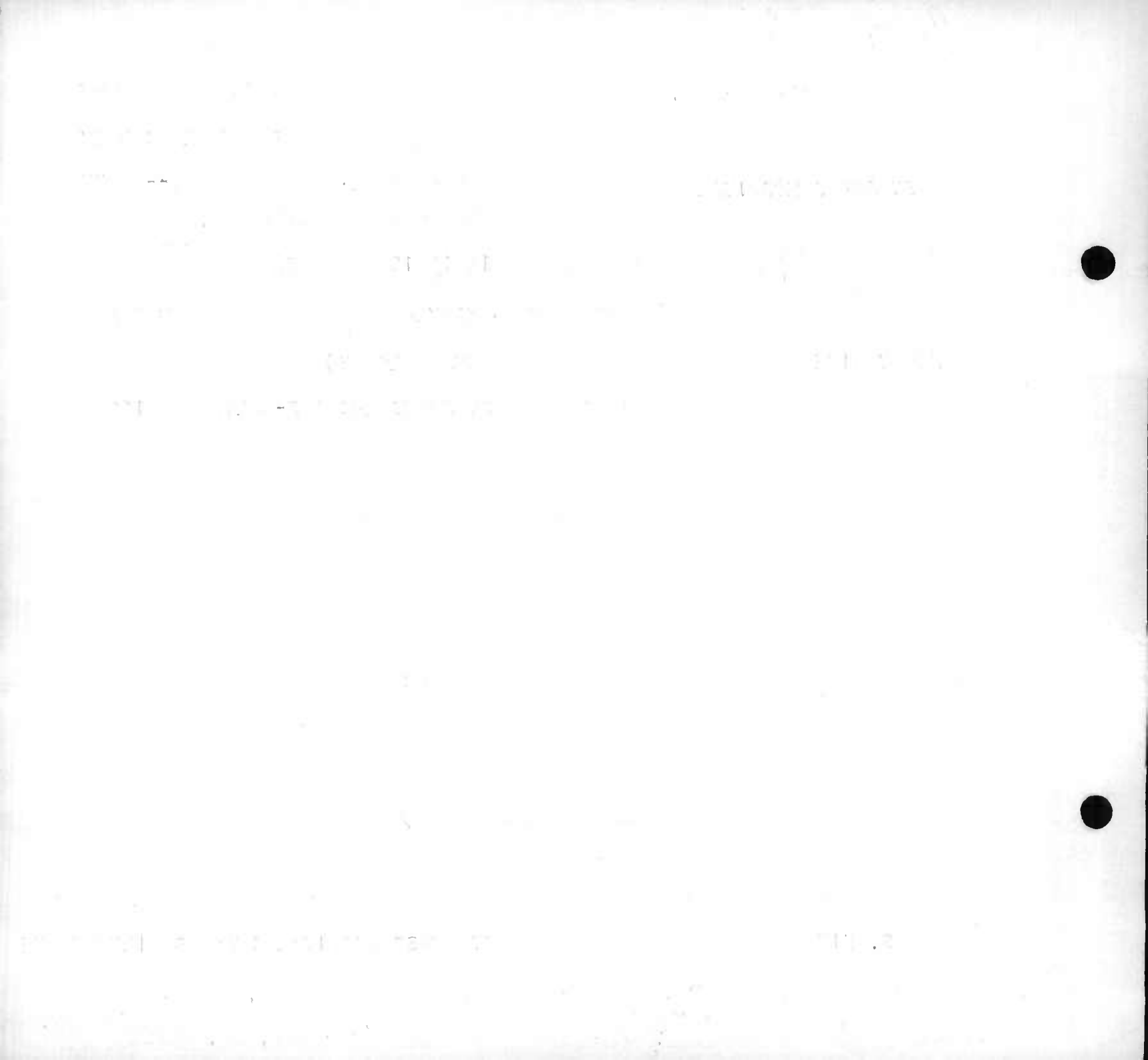
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4361	
8-363 71 4361 CERTIFICATE OF DEATH DATE		BIRTH NO. 1. NAME OF DECEASED (Type or Print) Stewart, Daurine W.		2. DATE AND HOUR OF DEATH 5/2/71 10:45 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Baltimore 2644 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5438 Sarril Road			
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/31/27	9. AGE (in years last birthday) 43	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder		10B. KIND OF BUSINESS OR INDUSTRY Unemployed Recently		11. BIRTHPLACE (State or foreign country) Kentucky	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Coxbert Farley		14. MOTHER'S MAIDEN NAME Edith Smith			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. 219-10-1958		17. INFORMANT Mr. Hugh Stewart, Husband ADDRESS same address	
II CAUSE OF DEATH					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) POST operative cardiac arrhythmia arrest		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Drainage of Pelvic Abscess, Sub- Total Hysterectomy, Transverse col. (B) DUE TO, OR AS A CONSEQUENCE OF: Chronic & acute Tuberculosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 days 9 days	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 4/23/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Pelvic Abscess		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (I) (this hospital) attended the deceased from 4/5 1971 to 5/2 1971 that (I) (we) lost her the deceased alive on 5/2 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE H. Earl Cotman, M.D.		23B. DATE SIGNED 5/5/71		23C. PHYSICIAN'S NAME (Type) H. EARL COTMAN, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 5/5/71		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cemetery	
25A. DATE REC'D BY HEALTH DEPT. MAY 6 1971		25B. NAME OF REGISTRAR Robert E. Kelly, Jr.		25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto Md. 21213	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4362	
P-624 71 4362 BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Preissler, Evelyn M.		2. DATE AND HOUR OF DEATH April 30th, 1971 1:55 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY ANNE ARUNDEL COUNTY C. CITY OR TOWN Pasadena M. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 238 Glen Road Pasadena Md.			
5. SEX F	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 12 12	9. AGE (In years last birthday) 58	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cafeteria		10B. KIND OF BUSINESS OR INDUSTRY Westinghouse Corp.		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME HENRY WISE		14. MOTHER'S MAIDEN NAME EVA (ELGERT)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214 16 8477		17. INFORMANT ADDRESS ST AGNES RECORDS-BALTO MD 21229	
18. 180X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE dehydration. DUE TO, OR AS A CONSEQUENCE OF: cervical carcinoma (B) metastasis DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH about 9 years.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-20 19 71 to 4-30 19 71 , that (I) (we) last saw the deceased alive on 4-30 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S. Kim		23B. DATE SIGNED 4-30-71		23C. PHYSICIAN'S NAME (Type) S. KIM	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/4/71		24C. NAME of CEMETERY or CREMATORY Holy Cross Cemetery	
24D. LOCATION Baltimore, Maryland		24E. ADDRESS ST AGNES HOSPITAL CATON & WILKENS AVE			
25A. DATE REC'D BY HEALTH DEPT. MAY 6 1971		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR George J. Gonce ADDRESS 4001 Ritchie Hgy. Baltimore, Md. 21225	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>71 4363</u>	
<p>A-226</p> <p>BIRTH NO. <u>71 4363</u></p>		<p>1. NAME OF DECEASED (Type or Print) <u>William Ashcroft</u></p>					
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p><u>Bolton Hill</u></p>		<p>2. DATE AND HOUR OF DEATH <u>4-30-71</u> <u>8:20 am</u> M.</p> <p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u></p> <p>C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>1226 North Calvert St. Baltimore 2, Md.</u></p>					
<p>5. SEX <u>M</u></p>		<p>6. RACE <u>White</u></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/></p> <p>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>5/28/93</u></p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p><u>Taxidriver</u></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p> <p><u>Taxi</u></p>		<p>11. BIRTHPLACE (State or foreign country)</p> <p><u>Pa.</u></p>		<p>12. CITIZEN OF WHAT COUNTRY?</p> <p><u>U.S.A.</u></p>	
<p>13. FATHER'S NAME</p> <p><u>David Ashcroft</u></p>				<p>14. MOTHER'S MAIDEN NAME</p> <p><u>Margaret Madegan</u></p>			
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO.</p> <p><u>206-01-7665</u></p>		<p>17. INFORMANT ADDRESS</p> <p><u>Admission Record</u></p>			
<p>18. <u>43391</u> CAUSE OF DEATH</p>							
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>						<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> <p><u>5 days</u></p> <p><u>5 days</u></p> <p><u>years</u></p>	
<p>II</p>							
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>							
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No)</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			
<p>21D. TIME OF INJURY (APPROX.)</p>		<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>			
<p>22. I certify that <u>He</u> (this hospital) attended the deceased from <u>11-14</u> 19<u>70</u> to <u>4/30</u> 19<u>71</u> that <u>He</u> (we) last saw the deceased alive on <u>4/30</u> 19<u>71</u> and that <u>He</u> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <u>He</u> (We) (did) (did not) view the body after death.</p>							
<p>23A. SIGNATURE</p> <p><u>Aderacion B. Paulino</u></p>				<p>23B. DATE SIGNED</p> <p><u>4/30/71</u></p>		<p>23C. PHYSICIAN'S NAME (Type)</p> <p><u>Aderacion B. Paulino</u></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify)</p> <p><u>Burial</u></p>		<p>24B. DATE</p> <p><u>5/4/71</u></p>		<p>24C. NAME OF CEMETERY OR CREMATORY</p> <p><u>Glen Haven Mem. Pk.</u></p>		<p>24D. LOCATION (City, town, or county) (State)</p> <p><u>Baltimore, Maryland</u></p>	
<p>25A. DATE REC'D BY HEALTH DEPT.</p> <p><u>MAY 6 1971</u></p>		<p>25B. NAME OF REGISTRAR</p> <p><u>Robert A. Bailey, M.D.</u></p>		<p>25C. FUNERAL DIRECTOR ADDRESS</p> <p><u>George J. Gonce 4001 Ritchie Hwy. Baltimore, Maryland 21225</u></p>			

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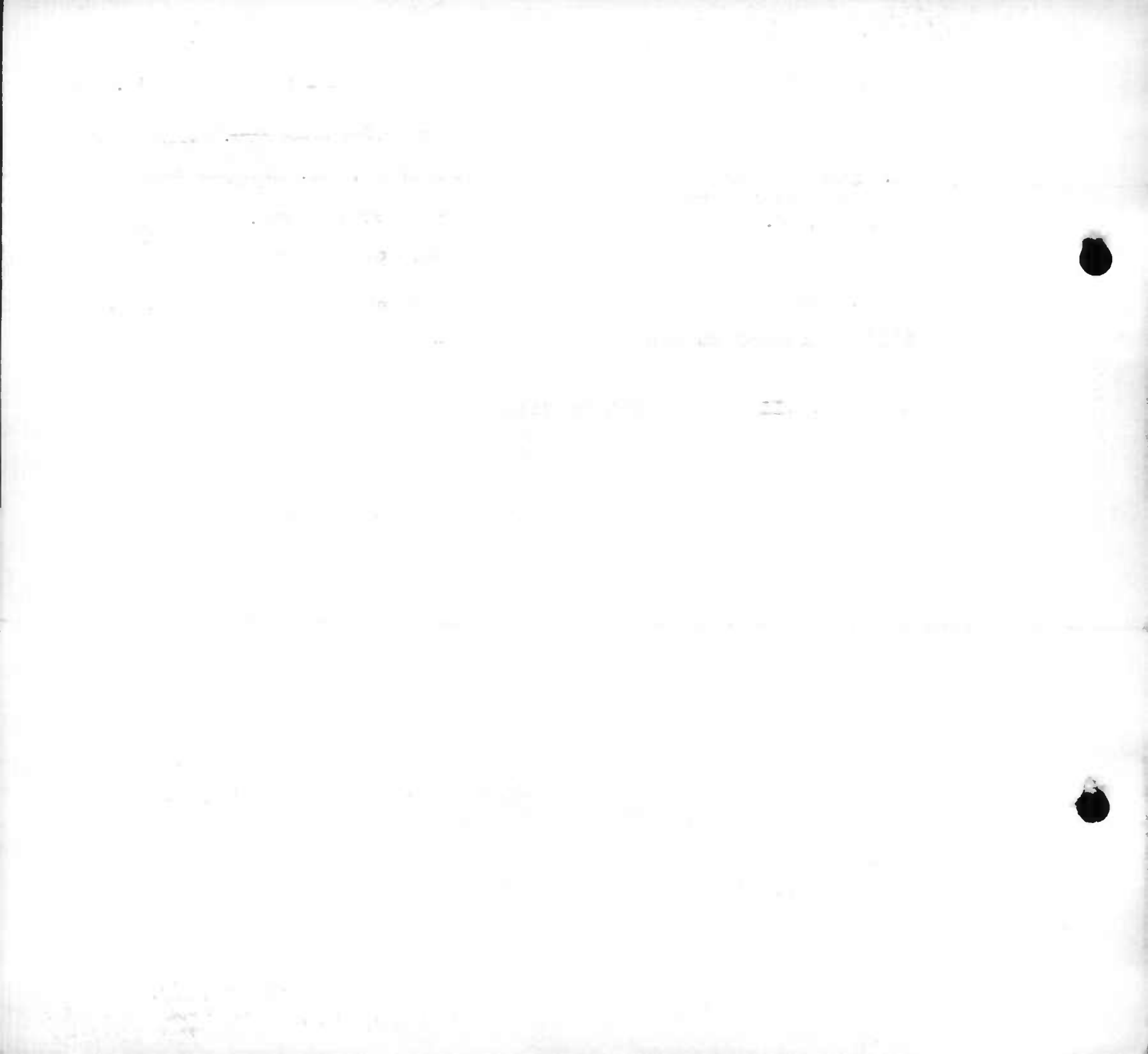
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

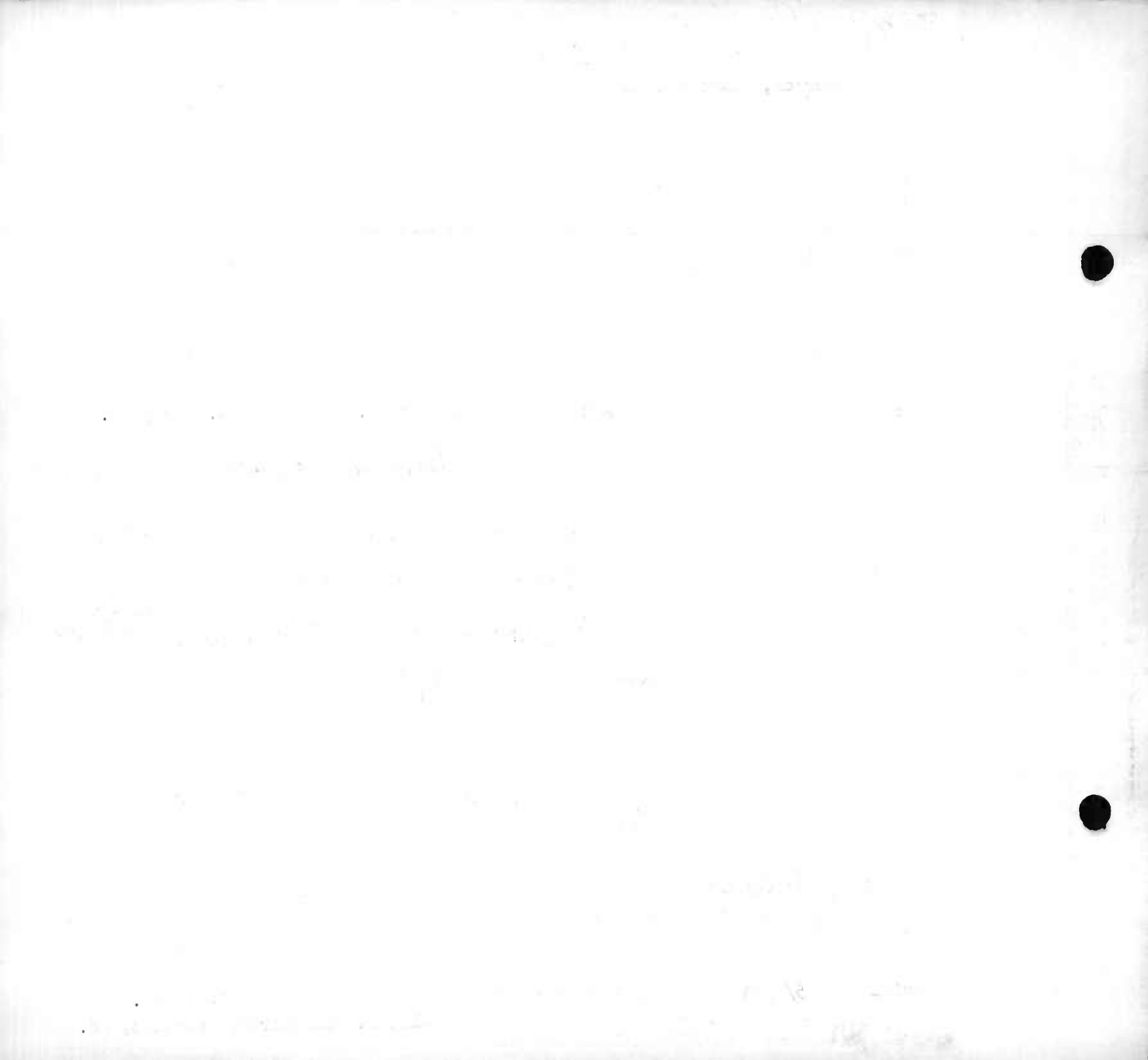
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4364	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) RAYMOND HUDSON		2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> 5-2-71 11:30PM </div>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) St. Agnes Hospital Caton & Wilkens Avenue Baltimore, Md.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) <div style="display: flex; justify-content: space-between;"> A. STATE B. COUNTY </div> 2045 Deering Ave. Maryland C. CITY OR TOWN Baltimore, Md. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2045 Deering Ave. 2582			
5. SEX m	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 13, 1918	9. AGE (in years last birthday) 52	10. UNDER 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Balto. Sun		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME William Richard Hudson			14. MOTHER'S MAIDEN NAME Myrtle Robinson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.II		16. SOCIAL SECURITY NO. 213 09 7311		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 35%;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH </div> </div> <div style="margin-top: 10px;"> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute MI - Coronary artery disease </div> <div style="margin-top: 10px;"> (B) DUE TO, OR AS A CONSEQUENCE OF: </div> <div style="margin-top: 10px;"> (C) DUE TO, OR AS A CONSEQUENCE OF: </div>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION May 2 1971		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 2 19 71 to May 2 19 71 that (I) (we) last saw the deceased alive on May 2 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Alejandro Meira				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) ALEJANDRO MEIRA				23D. ADDRESS St Agnes Hospital Caton & Wilkens Aves	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/6/71		24C. NAME OF CEMETERY OR CREMATORY Louden Park	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. MAY 6 1971			
25B. NAME OF REGISTRAR C. S. Mac Nabb		25C. FUNERAL DIRECTOR ADDRESS 301 Frederick Rd Baltimore Md 21228			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Badly burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
REG. NO. 71 4365											
<div> <div> A-536 101 4365 Anderson, Anna Phoebe </div> <div> BIRTH NO. 1. NAME OF DECEASED (Type or Print) </div> </div>											
<div> 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) </div>						<div> 2. DATE AND HOUR OF DEATH 5/3/71 8:35 AM 4. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) A. STATE RT. 2 MT Airy Md. 6000 B. COUNTY Frederick C. CITY OR TOWN Md. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER RT. 2 MT Airy Md. </div>					
5. SEX F		6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-3-10		9. AGE (in years last birthday) 61		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Moore						14. MOTHER'S MAIDEN NAME Carrie Chaney					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Mrs Mary E. Timpson, Mt. Airy, Md.					
18. CAUSE OF DEATH											
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
(A) IMMEDIATE CAUSE Ruptured appendix March 1971 DUE TO, OR AS A CONSEQUENCE OF: (B) Pure me Sepsis 4/18/71 DUE TO, OR AS A CONSEQUENCE OF: (C) Renal shut down 5/2/71											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Ruptured appendix 3/2/71 Exp. l. 4/24/71											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? Yes or No? No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If medical examined)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/28 19 11 to 5/3 19 71 that (I) (we) last saw the deceased alive on 5/3 19 71 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE S. SONGCHAROEN						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Health Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/3/71		23C. PHYSICIAN'S NAME (Type) S. SONGCHAROEN	
23D. ADDRESS University of Maryland Hosp						23E. ADDRESS					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 5/5/71		24C. NAME of CEMETERY or CREMATORY Pleasant Grove				24D. LOCATION (City, town, or county) (State) Purgum, Md.	
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR Olin L. Molesworth, Md.				25C. FUNERAL DIRECTOR ADDRESS Olin L. Molesworth, Damascus, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. <u>71 4366</u>	
T-620 71 4366				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) SHIRLEY TREAS				2. DATE AND HOUR OF DEATH 05/02/71 7:20 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MD. B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 38 B FENWAY SOUTH			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11-04-20		9. AGE (In years last birthday) 50	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assembler			10B. KIND OF BUSINESS OR INDUSTRY Aircraft		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME WILLIAM C. HUNINGER				14. MOTHER'S MAIDEN NAME NELLIE HINE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service No		16. SOCIAL SECURITY NO. 203 20 2311		17. INFORMANT Barry K. Treas 2903 Conroy Ct. Balto., Md.			
18. 253.91-124X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) cardiac arrest ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. query adrenal crisis hypophysectomy				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate 2-3 hours 6 days			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). metastatic carcinoma of the (R) breast							
19A. DATE OF OPERATION 04-26-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED persistent pain		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <input type="checkbox"/>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <input type="checkbox"/>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <input type="checkbox"/>			
22. I certify that (this hospital) attended the deceased from 4/22 1971 to 5/2 1971 that (we) last saw the deceased alive on 5/2 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE Robert T. Snowden, MD				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5/2/71	
23C. PHYSICIAN'S NAME (Type) ROBERT T. SNOWDEN M.D.				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/6/71		24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 6 1971		25B. NAME OF REGISTRAR Robert E. Treas, M.D.		25C. FUNERAL DIRECTOR Bruzdzinski Funeral Home 1407 Eastern Ave.			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

REG. NO.

71 4367

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

HAWK, MAYNARD

2. DATE AND HOUR OF DEATH

MAY 3, 1971

8:00P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

ST AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

ODENTON

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

485 BRUCE AVE

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

05 05 17

9. AGE (In years
last birthday)

53

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

MECHANIC - Electrical

10B. KIND OF BUSINESS OR INDUSTRY

Friendship Airport

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U S A

13. FATHER'S NAME

ELIJAH HAWK

14. MOTHER'S MAIDEN NAME

ALICE MILLS

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

WW-2

16. SOCIAL
SECURITY NO.

217092477

17. INFORMANT

BALTIMORE MD 21229
ST AGNES RECORDS WILKENS & CATON AVES

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

2 weeks

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (X) (this hospital) attended the deceased from APRIL 20 19 71 to MAY 3 19 71
that (X) (we) last saw the deceased alive on MAY 3 19 71 and that in (X) (our) opinion death occurred on the date
and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S
NAME (Type)

RALPH UPDIKE M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

5/4/71

23D. ADDRESS

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

7 May 71

24C. NAME of CEMETERY or CREMATORY

Fairview Cemetery

24D. LOCATION

(City, town, or county)

(State)

Harpers Ferry, West Virginia

25A. DATE REC'D BY HEALTH DEPT.

MAY 6 1971

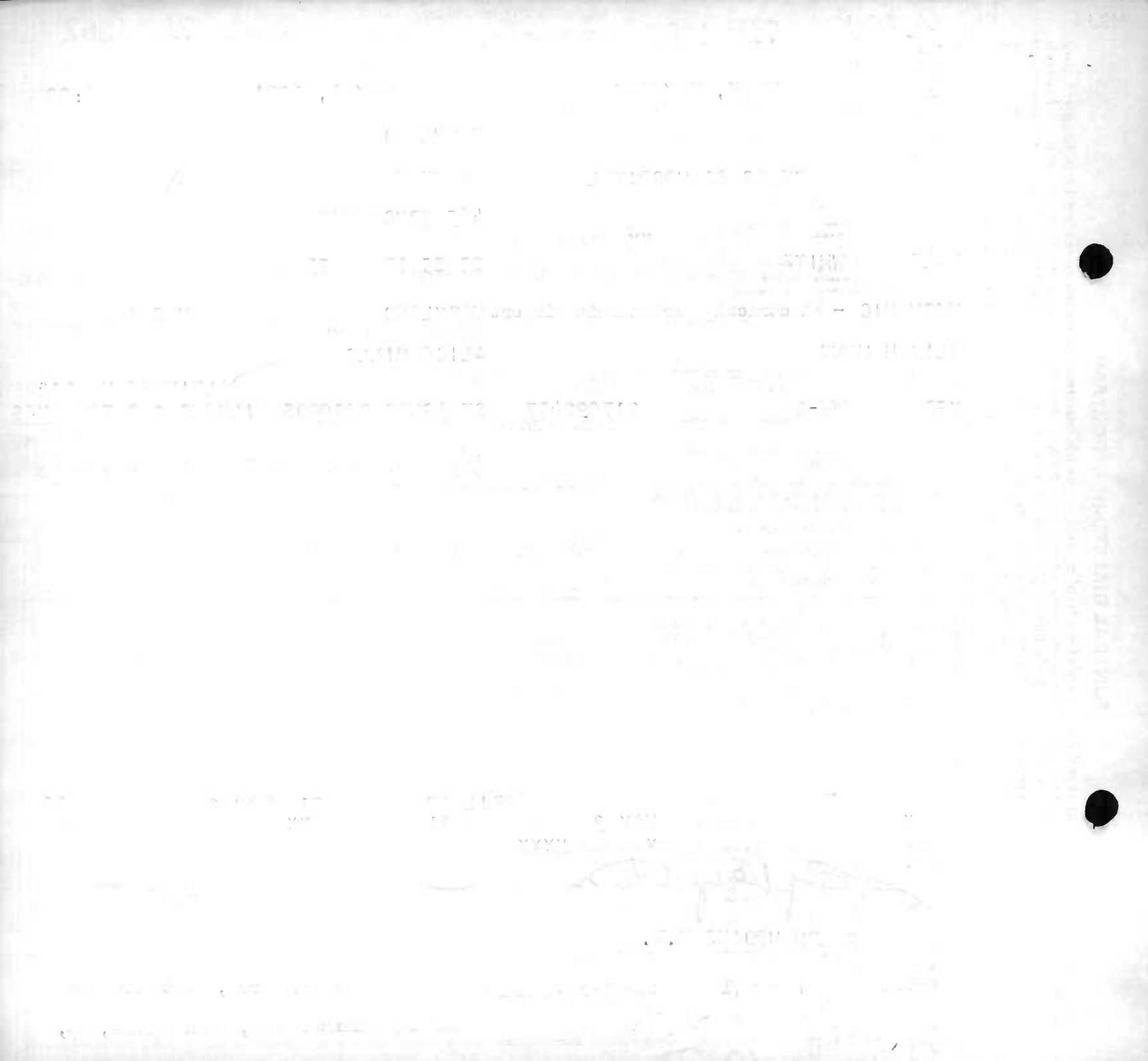
25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

Kirkley Funeral Home, Glen Burnie, Md.



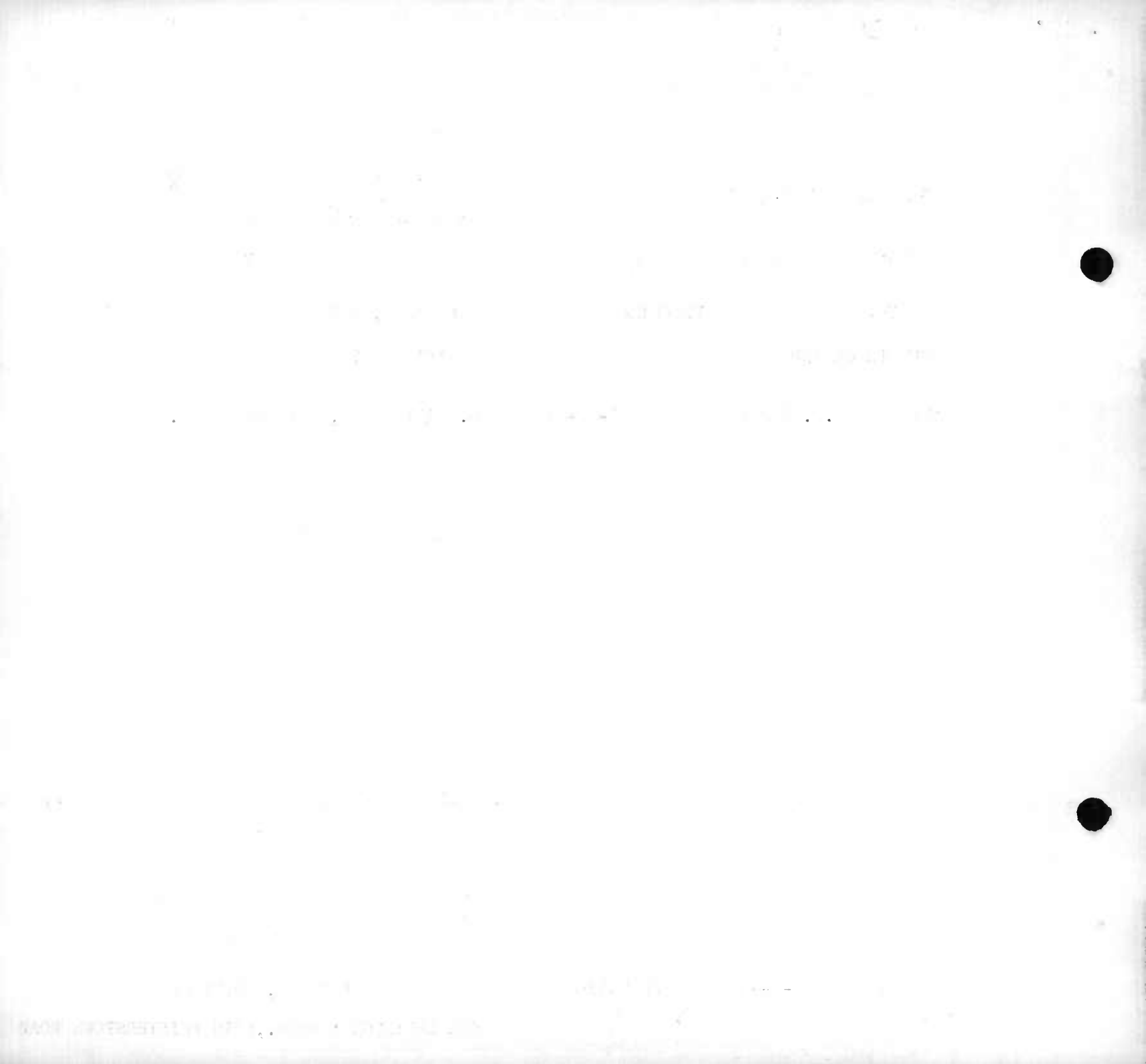
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
		Samuel D. Fraker		Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month 5 Day 3 Year 71		Month 5 Day 3 Year 71		A. STATE Md. B. COUNTY Baltimore	
6. SEX male		7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 1541 Covington St.	
9. DATE OF BIRTH Sept. 21, 1898		10. AGE (In years last birthday) 72		11. BIRTHPLACE (State or foreign country) Penna		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William D. Fraker		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steam Fitter	
15. MOTHER'S MAIDEN NAME Anna M. Lohman		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 152 09 2021		18. INFORMANT Dorothy H. Fraker		ADDRESS Above Address		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		Arteriosclerotic cardiovascular disease		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
		ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO, OR AS A CONSEQUENCE OF:					
		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(C) DUE TO, OR AS A CONSEQUENCE OF:					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)							
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK		22F. HOW DID INJURY OCCUR?							
23.		I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER		DATE SIGNED					
ACTUAL SIGNATURE		EXAMINER'S NAME (Type) Peter Lipkovic, M.D.		ASSISTANT MEDICAL EXAMINER		ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>				5/3/71	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 5/6/71		24C. NAME of CEMETERY or CREMATORY Antietam Cemetery		24D. LOCATION (City, town, or county) (State) Waynesboro Penna.					
25A. DATE REC'D BY HEALTH DEPT. MAY 6 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS McGully 130 E. Fort Ave. Baltimore, Md.							

Stefan

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

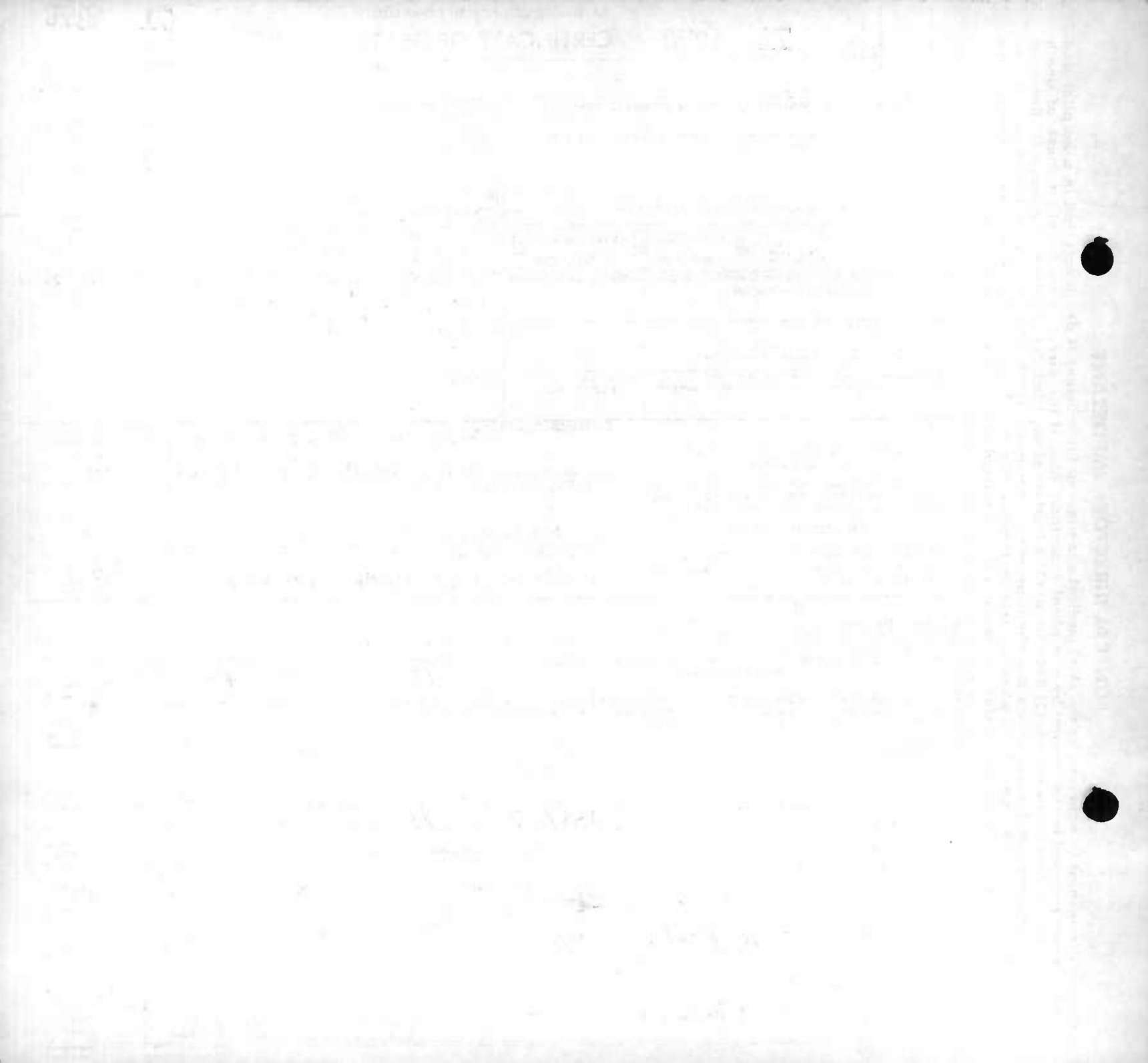
L-150		71 4369		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 4369	
1. NAME OF DECEASED (Type or Print) HERMAN LOUISA LEVINE				2. DATE AND HOUR OF DEATH 5-1-71 10:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION BELVEDERE NURSING HOME IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2740			
5. SEX MALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9. AGE (in years last birthday) 77 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRIVER		10B. KIND OF BUSINESS OR INDUSTRY TRUCKING		11. BIRTHPLACE (State or foreign country) CLEVELAND, OHIO		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOSEPH LEVINE				14. MOTHER'S MAIDEN NAME IDA ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W. I ARMY		16. SOCIAL SECURITY NO. 283-03-3401		17. INFORMANT ADDRESS MRS. MARY JACOB, 3610 GLEN AVE. #21215			
18. 4-12-71 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenie, etc. It means the disease, injury or complication which caused death.) Cardiac arrest ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Pulmonary Embolus Arteriosclerotic Cardiac Vas Disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). "Stroke" - April 3, 1971							
19A. DATE OF OPERATION 5-1-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Dec 15 1959 to May 1, 1971 that (I) was last saw the deceased alive on 5-1-1971 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) did (did not) view the body after death.							
23A. SIGNATURE <i>Samuel V. Tompakou</i>				23B. DATE SIGNED 5-1-71		23C. PHYSICIAN'S NAME (Type) SAMUEL V. TOMPAKOU, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5-4-71		24C. NAME of CEMETERY or CREMATORY AITZ CHAIM		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. MAY 6 1971		25B. NAME OF REGISTRAR Paula E. Pugh, M.D.		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

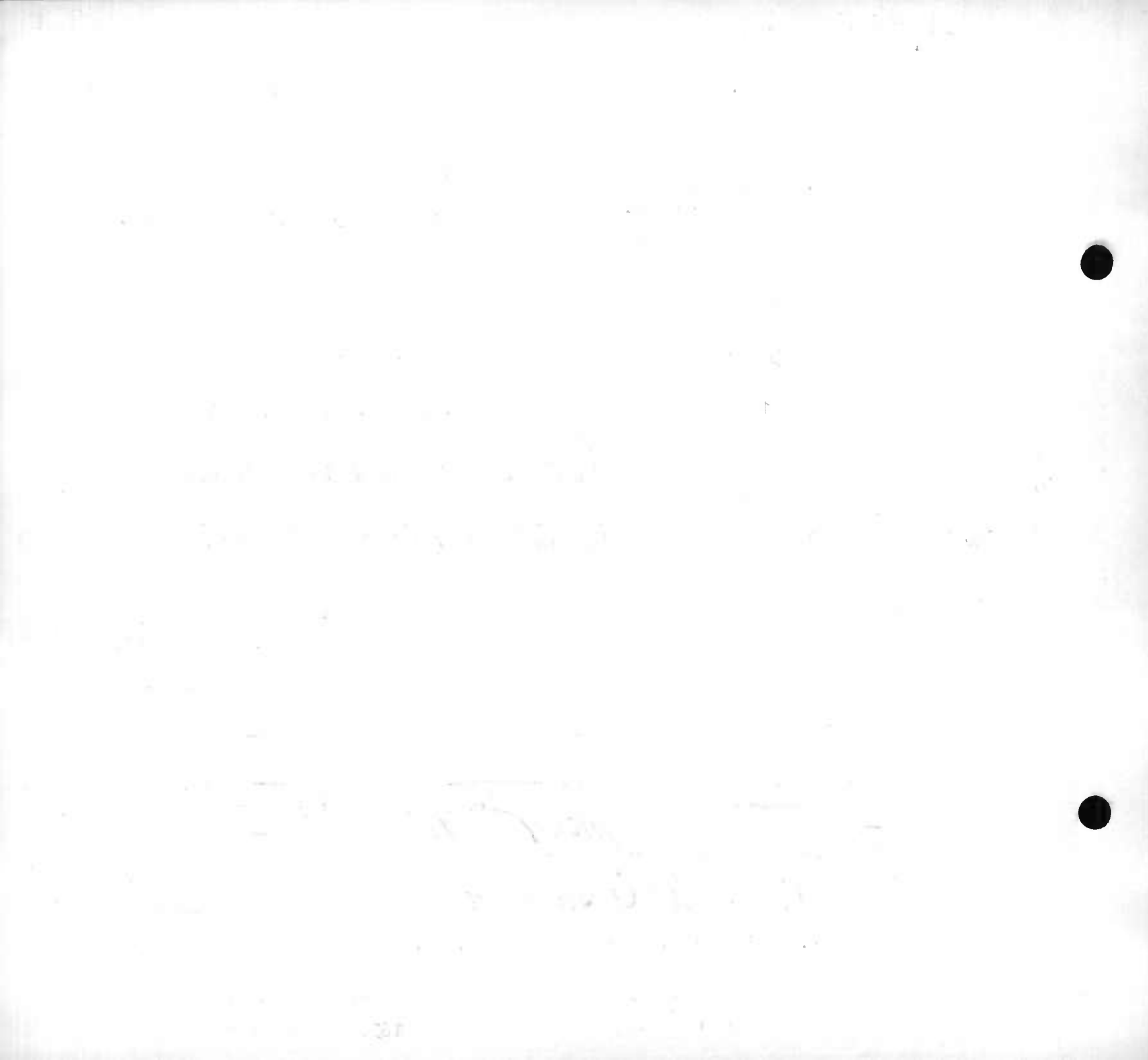
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4370	
BIRTH NO. M-440 71 4370		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MULLER, Raymond			2. DATE AND HOUR OF DEATH 5/3/71 9:27 a.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 The Johns Hopkins Hospital			4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 318 St. George Road		
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/1/71	9. AGE (In years last birthday) 2	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) St. Joseph's Hospital Baltimore, Md.		
13. FATHER'S NAME Raymond Muller			14. MOTHER'S MAIDEN NAME Lois Stusberry		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT			ADDRESS		
18. 746.81 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (CONGENITAL HEART DISEASE) (A) IMMEDIATE CAUSE HYPOPLASTIC LEFT HEART DUE TO, OR AS A CONSEQUENCE OF: (B) METABOLIC ACIDOSIS DUE TO, OR AS A CONSEQUENCE OF: (C) CONGESTIVE HEART FAILURE		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2d 1d 1 1/2d					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from MAY 2 19 71 to MAY 3 19 71 that (I) (we) last saw the deceased alive on MAY 3 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE ER Pearl MD			23B. DATE SIGNED 5/3/71		
23C. PHYSICIAN'S NAME (Type) ELLIOTT R. PEARL MD			23D. ADDRESS JOHNS HOPKINS HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Cremation	5/4/71	Johns Hopkins Hospital		601 N Broadway, Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 6 1971			25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

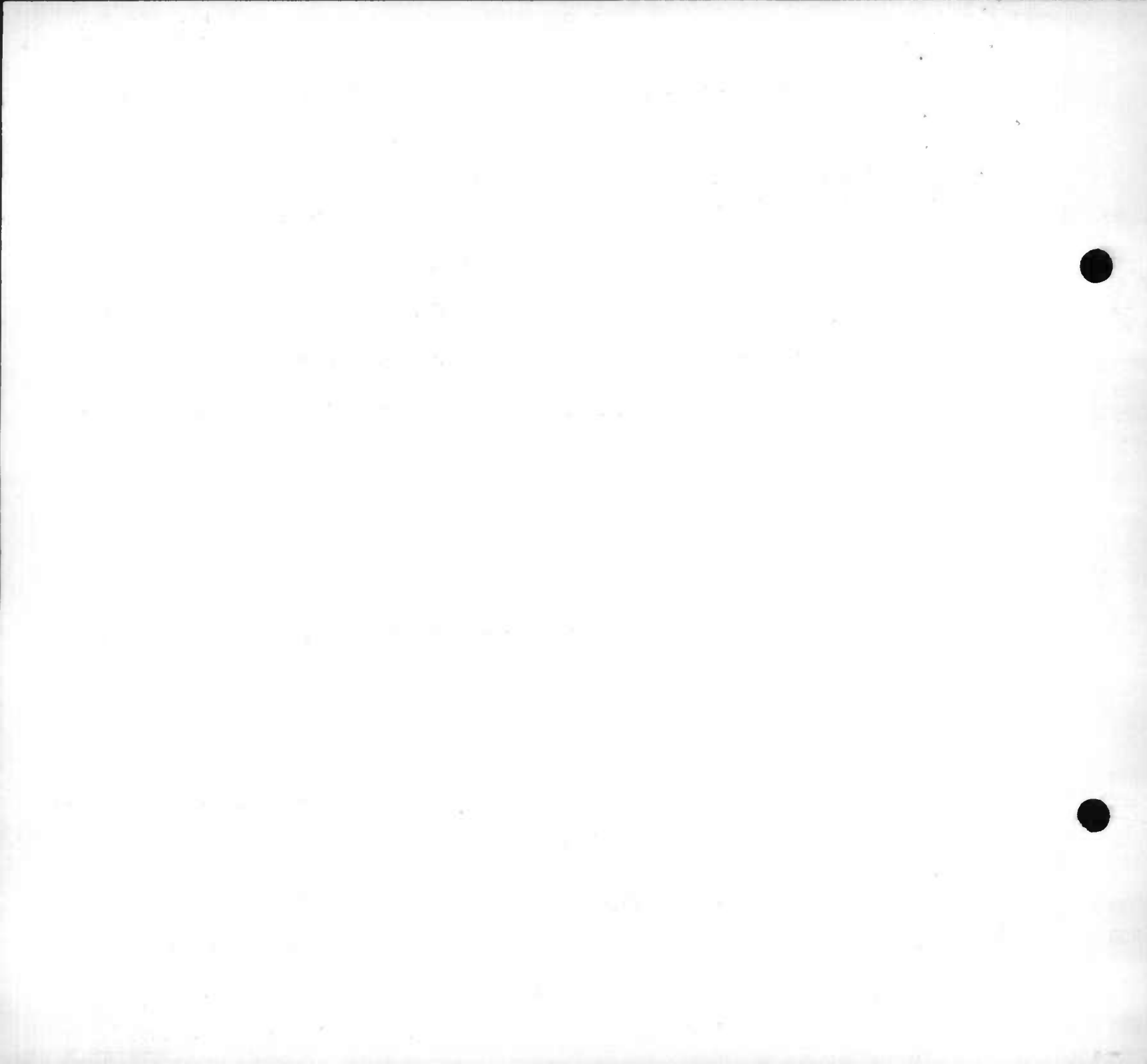
J-525 71 4371		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		71 4371 REG. NO.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) John B. Johnson		2. DATE AND HOUR OF DEATH 5/4/71 9P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital Wilkens & Caton Ave.		4. USUAL RESIDENCE (Where deceased lived, if in institution; residence before admission) A. STATE Md B. COUNTY Howard C. CITY OR TOWN Ellicott City D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 8421 Glen Mar, Ellicott City, Md.			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/5/1894	9. AGE (In years last birthday) 76	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Mechanic		10B. KIND OF BUSINESS OR INDUSTRY Md State Police		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Late John Johnson		14. MOTHER'S MAIDEN NAME Late Caroline	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes WW 1		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Anna M. Johnson, 8421 Glen Mar, 21043	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 470.9 I Myocardial infarction		CAUSE OF DEATH (A) IMMEDIATE CAUSE Anterolateral C.V. dis DUE TO, OR AS A CONSEQUENCE OF: (B) 2 year DUE TO, OR AS A CONSEQUENCE OF: (C) Penicilliosis Arterios 20+ years		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 1965 to April 1971 and that (I) (we) last saw the deceased alive on April 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Christian S. Mass				23B. DATE SIGNED 5/5/71	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS 21 S. St. Johns Lane, Ellicott City, Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/8/71		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. MAY 6 1971		25B. NAME OF REGISTRAR Robert E. Barber, M.D.	
25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Ave., 21228		25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 4372	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) Rita Eugenia Hauth		2. DATE AND HOUR OF DEATH May 4, 1971 12: 01 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital 3100 Wyman Parkway		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2834 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4806 Coleherne Road 21229			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/20/18	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse- Hwf,		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 52 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Arthur Schuster -deceased		14. MOTHER'S MAIDEN NAME Rita Bannon -deceased			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-18-4565		17. INFORMANT Records- US PHS Hospital, Balto, Md. ADDRESS	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			Pneumonia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			Metastatic adenocarcinoma rt. ovary		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Apr. 6 19 71 to May 4 19 71 that (I) (we) last saw the deceased alive on May 4 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE R. Roger Little, M.D.				23B. DATE SIGNED 5/4/71	
23C. PHYSICIAN'S NAME (Type) R. Roger Little, Surgeon (R)				23D. ADDRESS US PHS Hospital, Balto, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/7/71		24C. NAME OF CEMETERY or CREMATORY Arlington Nat'l Cemetery	
24D. LOCATION (City, town, or county) (State) arlington, Virginia		25A. DATE REC'D BY HEALTH DEPT. MAY 6 1971 25B. NAME OF REGISTRAR Robert E. Huber, M.D.			
25C. FUNERAL DIRECTOR Witzke, 4101 Edmondson Ave., 21229				ADDRESS	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

RONALD T. JOHNSON

2. DATE OF DEATH
Known ☐ Estimated ☐

Month Day Year Hour

3. DATE PRONOUNCED DEAD

Month Day Year Hour

May 4, 1971

5:15 P. M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

BALTO. CITY HOSPITAL

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Baltimore

5300

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

9. DATE OF BIRTH

June 11, 1949

10. AGE (In years last birthday)

21

11. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

103 Sollers Pt. Rd.

11. BIRTHPLACE (State or foreign country)

Balto, Md.

12. CITIZEN OF WHAT COUNTRY?

U. S. a.

13. FATHER'S NAME

James A. Johnson

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Supervisor

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Frances Williams

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

Linda Johnson 103 Sollers Pt. Rd.

19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

Stab wound of chest

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

School Ground

22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Rear of Regional Vocational School, Dundalk

22D. TIME OF INJURY (APPROX.)

5-4-71

22E. INJURY OCCURRED

WHILE AT WORK ☒

NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

Stabbed by unknown assailant

23. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE

Ronald N. Kornblum, M.D.

NAME (Type)

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/5/71

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

5-7-71

24C. NAME of CEMETERY or CREMATORY

Lorraine Cemetery

24D. LOCATION (City, town, or county)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

MAY 6 1971

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Morton & Dyett F. H. 1701 Laurens Street

June 11, 1960

Mr. J. E. [unclear]

Director

James A. [unclear]

Edward Williams

Miss [unclear] [unclear]

VALLEY FORGE
COSTUME SHOP

[unclear]

5-7-71

Ernie [unclear]

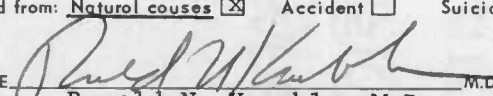
John [unclear]

From [unclear] [unclear]

BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) CLAUDE SCOTT				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 LUTHERAN HOSPITAL				3. DATE PRONOUNCED DEAD Month Day Year May 4, 1971 10:00 P.M.			
6. SEX Male				7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH October 23, 1930				10. AGE (In years last birthday) 40		11. BIRTHPLACE (State or foreign country) Greenville, S. C.	
12. CITIZEN OF U. S. A.				13. FATHER'S NAME Charles Foster		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian	
15. MOTHER'S MAIDEN NAME Daisey Scott				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (if yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Daisey Johnson				ADDRESS 2414 Arunah Avenue			
19. 481X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Lobar Pneumonia				CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Fatty Metamorphosis of Liver			
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) yes				22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22F. HOW DID INJURY OCCUR?				23.			
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED 5/5/71				24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 5-10-71				24C. NAME of CEMETERY or CREMATORY Arbutus Memeorial Pk.			
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland				25A. DATE REC'D BY HEALTH DEPT. MAY 6 1971			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.				25C. FUNERAL DIRECTOR ADDRESS Morton & Dyett F. H. 1701 LAurens St.			

October 12, 1950
Groenvelt, J. C.

Antonia

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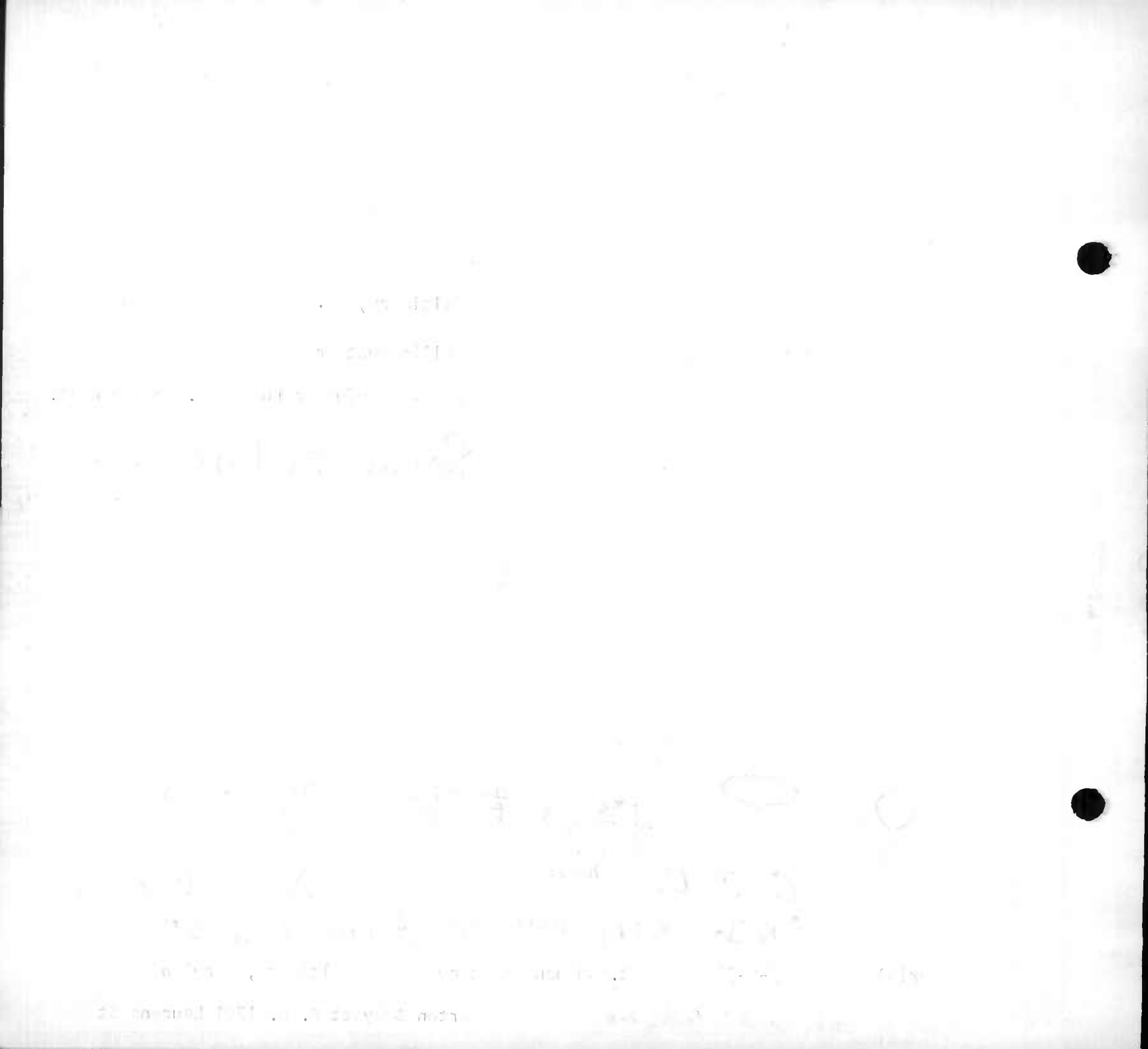
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Galaxy 5000000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4375	
CERTIFICATE OF DEATH					
BIRTH NO. 71 4375		1. NAME OF DECEASED (Type or Print) <u>Brown, Lewelyn</u>		2. DATE AND HOUR OF DEATH <u>5/5/71 @ 1:30 AM</u> <u>1 30 / A.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Lutheran Hospital of Maryland</u>			A. STATE <u>Maryland</u> B. COUNTY <u>1538</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Balto.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>2705 Roslyn Ave.</u>		
5. SEX <u>M</u>	6. RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-29-35</u>	9. AGE (in years last birthday) <u>35 ym.</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Rufus, Brown</u>			14. MOTHER'S MAIDEN NAME <u>Mallie Gunther</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Chart Rufus Brown 606 N. Appleton St.</u>
18. <u>54321</u>			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Renal Failure</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4-28-71</u> <u>to 5-5-71</u>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nally medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4-28-71</u> to <u>5-5-71</u> that (I) (we) last saw the deceased alive on <u>5-5-71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>O. J. Kim M.D.</u>				23B. DATE SIGNED <u>5-5-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>OK Dr Kim M.D.</u>				23D. ADDRESS <u>730 Ashburton St.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-8-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 6 1971</u>		25B. NAME OF REGISTRAR <u>Robert A. Taylor M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Morton & Dyett F. H. 1701 Laurens St</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 4376		REG. NO. 71 4376	
BIRTH NO. <u>K-200</u>		71 4376		71 4376		71 4376	
1. NAME OF DECEASED (Type or Print) <u>Inez Frances Keys</u>				2. DATE AND HOUR OF DEATH <u>5/4/71</u> <u>9:30 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>38 University Hospital Baltimore Md.</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>md.</u> B. COUNTY <u>Balt.</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>204 N. Vincent St.</u>			
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/18/24</u>	9. AGE (In years lost birthday) <u>47</u>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>n/a</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>n/a</u>		11. BIRTHPLACE (State or foreign country) <u>Sumpton S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>Mary Brown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Frances Pratt</u>		ADDRESS <u>1004 - N. Vincent</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Septic Coma</u> (B) <u>Chronic Alcoholism</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Fatty Liver</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>16 hrs.</u> <u>20 years</u> <u>6 years</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>5/4/71</u> 19 <u>71</u> to <u>5/4</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>5/4</u> 19 <u>71</u> and that (in) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Stephen B. Greenberg</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>5/4/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Stephen Greenberg</u>				23D. ADDRESS <u>Un. Hospital</u>			
24A. BURIAL/CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-7-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cemetery Baltimore Md.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 6 1971</u>		25B. NAME OF REGISTRAR <u>Robert J. Taylor, Md.</u>		25C. FUNERAL DIRECTOR <u>Mortuaries Dyer H.F.H. 1701 - Laurens St.</u>		ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 4377	
CERTIFICATE OF DEATH				71 4377	
BIRTH NO.				REG. NO.	
1. NAME OF DECEASED (Type or Print) Kuhl, Mary C			2. DATE AND HOUR OF DEATH May 5, 1971 11:52 a.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital, Inc.			A. STATE Maryland		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2600 Liberty Heights Avenue			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
39 Baltimore, Maryland 21215			E. STREET AND NUMBER 3520 Hilton Street		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 5-1894	9. AGE (In years last birthday) 86	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore
13. FATHER'S NAME LOUIS JACOB			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 218-03-6170		17. INFORMANT MRS Regina White - 1110 CLINTON St
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ASCD is congestive heart failure			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Diabetes mellitus		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-22-71 to 5-5-71 and that (I) (we) lost the deceased alive on 5-5-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Eljah Saunders			23B. DATE SIGNED 5/5/71		23C. PHYSICIAN'S NAME (Type) ELIJAH SAUNDERS
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 5/8/71		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cem
25A. DATE REC'D BY HEALTH DEPT. MAY 6 1971			25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Thomas J. Kennedy
25D. LOCATION (City, town, or county) Baeto Md			25E. ADDRESS 1600 Hollins		

21112 Baltimore, Maryland
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21112

3520 Wilson Avenue

21112

Baltimore

21112

21112-03-21112

2-2-71

4-22-71

2-2-71

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>21 4378</u>	
BIRTH NO. <u>H-635 71 4378</u>							
1. NAME OF DECEASED (Type or Print) <u>Ernest Harden</u>				2. DATE AND HOUR OF DEATH <u>May 4, 1971</u> <u>2:20</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>33</u> <u>JOHNS HOPKINS HOSPITAL</u>				A. STATE <u>MARYLAND</u>		B. COUNTY <u>704</u>	
				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>805 N. WASHINGTON ST.</u>			
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-8-12</u>	9. AGE (In years last birthday) <u>58</u>	10. Under 1 Yr. Months: Days:	11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Shepherd Pratt Hosp</u>		11. BIRTHPLACE (State or foreign country) <u>S.C.</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>ANDERSON</u>			14. MOTHER'S MAIDEN NAME <u>MARY Brown</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>250-03-3634</u>		17. INFORMANT <u>Nancy Harden Dugg</u>		
			ADDRESS <u>1052 N. Duvall</u>				
18. <u>431.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CARDIAC ARREST</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>—</u>	
				(B) <u>INTERNAL CAPSULAR HEMORRHAGE</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>1 month</u>	
				(C) <u>CEREBRAL VASCULAR DISEASE</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>APRIL 9</u> 19 <u>71</u> to <u>MAY 4</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>MAY 4, 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>R Shore</u>				23B. DATE SIGNED <u>May 8, 1971</u>		23C. PHYSICIAN'S NAME (Type) <u>R SHORE</u>	
				23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>5/7/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Griffith</u>		24D. LOCATION (City, town, or county) (State) <u>M.C. Connolly S.C.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 6 1971</u>				25B. NAME OF REGISTRAR <u>Joseph E. Lock</u>			
				25C. FUNERAL DIRECTOR <u>Joseph E. Lock</u>			
				ADDRESS <u>1304 N. Central</u>			

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71 4378		BALTIMORE CITY HEALTH DEPARTMENT	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 71 4378	
BIRTH NO.			
1. NAME OF DECEASED (Type or Print) Gussie Harris		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2912 Rockrose Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour 5 4 71 8:55 a M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1703		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
6. SEX female	7. RACE colored	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH	10. AGE (In years last birthday) 70	11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF USA		13. FATHER'S NAME Clarence Holt	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Mamie Thomas		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT Mrs Elizabeth Niles, same	
19. 412.4		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner 5/4/71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/7/71	
24C. NAME OF CEMETERY or CREMATORY MT Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, MD	
25A. DATE REC'D BY HEALTH DEPT MAY 6 1971		25B. NAME OF REGISTRAR John E. Taylor	
25C. FUNERAL DIRECTOR A Halstead		ADDRESS 1206 W North Ave	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4380	
BIRTH NO. 71 4380		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Walter Kuchera		2. DATE AND HOUR OF DEATH April 29 1971			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1435 E. Fort Avenue		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2401 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1435 E. Fort Avenue			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/18/94	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Russia	
12. CITIZEN OF WHAT COUNTRY? Russia		13. FATHER'S NAME Alexis Kuchera		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 25-09-3379		17. INFORMANT Helen Kuchera	
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CVA (B) ASCVD DUE TO, OR AS A CONSEQUENCE OF: (C) —		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Healing Burns in back		2 months			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 2-19 1971 to 4-29 1971 , that (I) (we) last saw the deceased alive on 4-26 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) E.H. Weiss	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/3/71		24C. NAME OF CEMETERY or CREMATORY Holy Cross Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. MAY 6 1971		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.	
25C. FUNERAL DIRECTOR Charles L. Stevens Funeral Home, Inc.		25D. ADDRESS 1501 East Fort Avenue			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO.
Y-650 71 4381		71 4381		
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Horace L. Varian</u>		2. DATE AND HOUR OF DEATH <u>5/5/71</u> <u>2:15 A</u> M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1101</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>18 Maryland General Hosp.</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>701 ST. PAUL ST.</u>				
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-14-84</u>	9. AGE (in years, months, days) <u>86</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SELF EMPLOYED</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>RELIGIOUS SUPPLIES</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>MILES A. VARIAN</u>		14. MOTHER'S MAIDEN NAME <u>BESSIE BAKER</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>249-30-8009</u>		17. INFORMANT <u>Horace L. Varian</u> Address <u>Boston, Massach.</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) <u>Bilateral bronchopneumonia</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Septicemia</u> DUE TO, OR AS A CONSEQUENCE OF: <u>By Pneumonia</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>a week</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Recurrent pulmonary emboli</u>				
19A. DATE OF OPERATION <u>2</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>Yes</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>Apr 28</u> 19 <u>71</u> to <u>May 5</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>May 5</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>R. Tsukamoto</u>		23B. DATE SIGNED <u>5/5/71</u>		
23C. PHYSICIAN'S NAME (Type) <u>R. Tsukamoto</u>		23D. ADDRESS <u>Md. Maryland General Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>5-7-1971</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 6 1971</u>	25B. NAME OF REGISTRAR <u>Robert E. Farber, R.D.</u>	25C. FUNERAL DIRECTOR <u>H. W. Jenkins & Sons Co.</u> ADDRESS <u>4905 York Road Balto., Md. 21212</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. <u>71 4382</u>	
BIRTH NO. <u>(U)-623 71 4382</u>				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Wright, Alice</u>				2. DATE AND HOUR OF DEATH <u>6-5-71</u> <u>10</u> <u>a</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 Union Memorial Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1410 Boyce Avenue, MD 21204</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-09-83</u>	9. AGE (In years last birthday) <u>87</u>	10. Under 1 Yr. Months	11. Under 1 Yr. Days	12. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>DAYTON OHIO</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA (AMERICAN)</u>							
13. FATHER'S NAME <u>FREDERICK W. WRIGHT</u>				14. MOTHER'S MAIDEN NAME <u>SARAH BRUGN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>ADRIAN H. MERRIMAN</u> ADDRESS <u>FALLS PT. - BROOKLANDVILLE, Md.</u>	
18. <u>71241</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(A) IMMEDIATE CAUSE <u>CARDIO RESPIRATORY APPRES</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>CHF - ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>04-30-71</u> 19 <u>71</u> to <u>5-5</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>5-5</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>5-5-71</u>		23C. PHYSICIAN'S NAME (Type) <u>JULIO BERTORINI</u> DEGREE _____	
23D. ADDRESS <u>UNION MEMORIAL HOSPITAL</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>5-5-71</u>		24C. NAME of CEMETERY or CREMATORY <u>Greenmount</u>		24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 6 1971</u>		25B. NAME OF REGISTRAR <u>Robert A. Farber, M.D.</u>		25C. FUNERAL DIRECTOR <u>H. W. Jenkins & Sons Co.</u>		ADDRESS <u>4905 York Road Balto., Md. 21212</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>Y-520</u> <u>71</u> <u>4383</u>				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. <u>71</u> <u>4383</u>	
1. NAME OF DECEASED (Type or Print) <u>Webster Young</u>				2. DATE AND HOUR OF DEATH <u>5/4/71</u> <u>800A</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 THE JOHNS HOPKINS HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1002</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>923 E. MADISON ST.</u>					
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-14-88</u>		9. AGE (In years last birthday) <u>82</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired laborer</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>S. Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ALBERT YOUNG</u>				14. MOTHER'S MAIDEN NAME <u>ELIZA TOLLIVER</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>217-09-2322</u>		17. INFORMANT <u>John Ware</u> ADDRESS <u>923 E. Madison St.</u>			
18. <u>342X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Prob. Pulmonary Embolism</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Immobility</u> <u>Dehydration, old age, senility</u> <u>Diagnosis: ? pulmonary embolism</u> <u>Alveolar effusion with atelectasis</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Immobility</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Dehydration, old age, senility</u> <u>Diagnosis: ? pulmonary embolism</u> <u>Alveolar effusion with atelectasis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>5 month</u> <u>years</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u>									
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR					
22. I certify that (I) (the hospital) attended the deceased from <u>4/25/71</u> 19 <u>71</u> to <u>5/4/71</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>5/4/71</u> 19 <u>71</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.									
23A. SIGNATURE <u>B. H. Bullock</u>				23B. PHYSICIAN'S NAME (Type) <u>B. H. Bullock</u>		23C. DATE SIGNED <u>5/4/71</u>		23D. ADDRESS <u>Johns Hopkins Hospital</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <u>5-8-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cen.</u>		24D. LOCATION (City, town, or county) (State) <u>A. A. County, Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 6 1971</u>				25B. NAME OF FUNERAL DIRECTOR <u>John E. Bullock</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Ches. J. H. 1129 N. (unint.)</u>			

THE COURT REPORTER

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4384

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 4384

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIE LEE WEST		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> May 5, 1971 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 831 Mc Kim Street		3. DATE PRONOUNCED DEAD Month Day Year May 5, 1971 12:00 M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1802			
6. SEX Male	7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore
9. DATE OF BIRTH 11-3-15		10. AGE (In years last birthday) 55	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	E. STREET AND NUMBER 1070 Fairmount Avenue
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY	13. FATHER'S NAME Willie Thomas West
15. MOTHER'S MAIDEN NAME Lu Anna Arrington			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 244-18-8087	18. INFORMANT Mrs. Lena D. West
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		ADDRESS 1070 Fairmount Ave. 21223	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-10-71	24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. MAY 6 1971		25C. FUNERAL DIRECTOR Marshall W. Jones, Jr.	
25B. NAME OF REGISTRAR Charles S. Springate		25D. ADDRESS 1735 Harford Ave. 21213	

VALLEY FORT

267 JUNE 1947

CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

KENNEDY, LAWRENCE LEROY

2. DATE AND HOUR OF DEATH

MAY 3, 1971

8.05 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

ST AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

MARYLAND BALTIMORE

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

YES ☒NO ☒

E. STREET AND NUMBER

5543 OREGON AVE ARBUTUS, MD 21227

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

05 31 89

9. AGE (In years last birthday)

81

If Under 1 Yr. Months: Days

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

BRAKEMAN

10B. KIND OF BUSINESS OR INDUSTRY

RAILROAD

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

EDWARD KENNEDY

14. MOTHER'S MAIDEN NAME

AUGUSTA (STAR)

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

705 07 2279

17. INFORMANT

ST AGNES HOSPITAL RECORDS CATON & WILKENS AVES BALTO MD 21229

ADDRESS

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

Pulmonary edema

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX)

(Month) (Day) (Year) (Hour)

5 3 71 8.05

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ☒ (this hospital) attended the deceased from 05/02 19 71 to 05/03 19 71 that ☒ (we) last saw the deceased alive on 05/03 19 71 and that in ☒ (our) opinion death occurred on the date and hour and from the causes stated above. ☒ (We) (did) ☒ (XXX) view the body after death.

23A. SIGNATURE

Benavides

DEGREE

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

5-3-71

23C. PHYSICIAN'S NAME (Type)

VICTOR BENAVIDES

M.D.

23D. ADDRESS

WILKENS & CATON AVE. BALTO MD. 21299

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

5/6/71

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Carmine J. 328 Sulphur Sp Rd.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Handwritten text, possibly a signature or name, appearing in the center of the page.

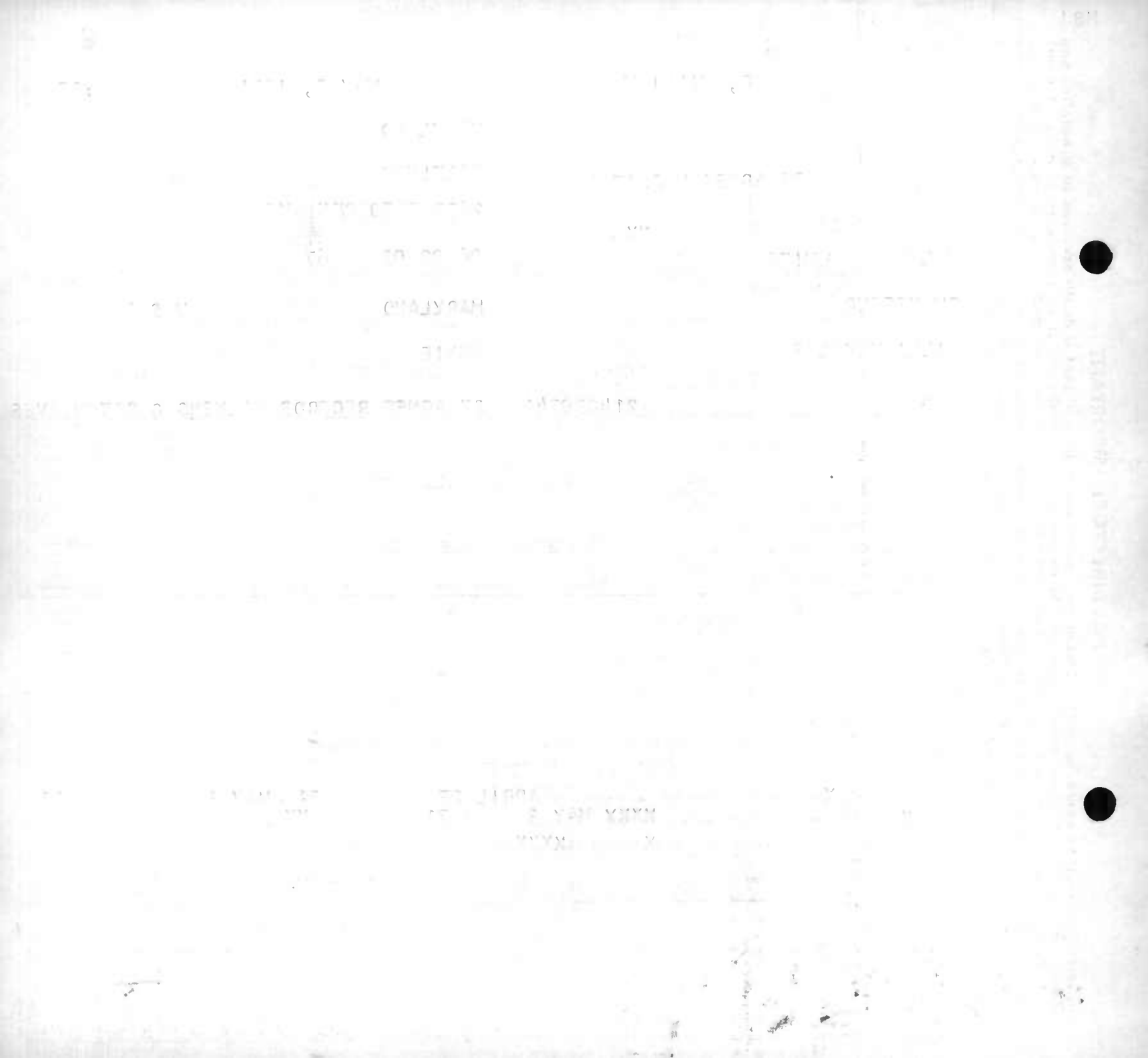
Handwritten signature or name at the bottom right of the page.

2000/08/10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

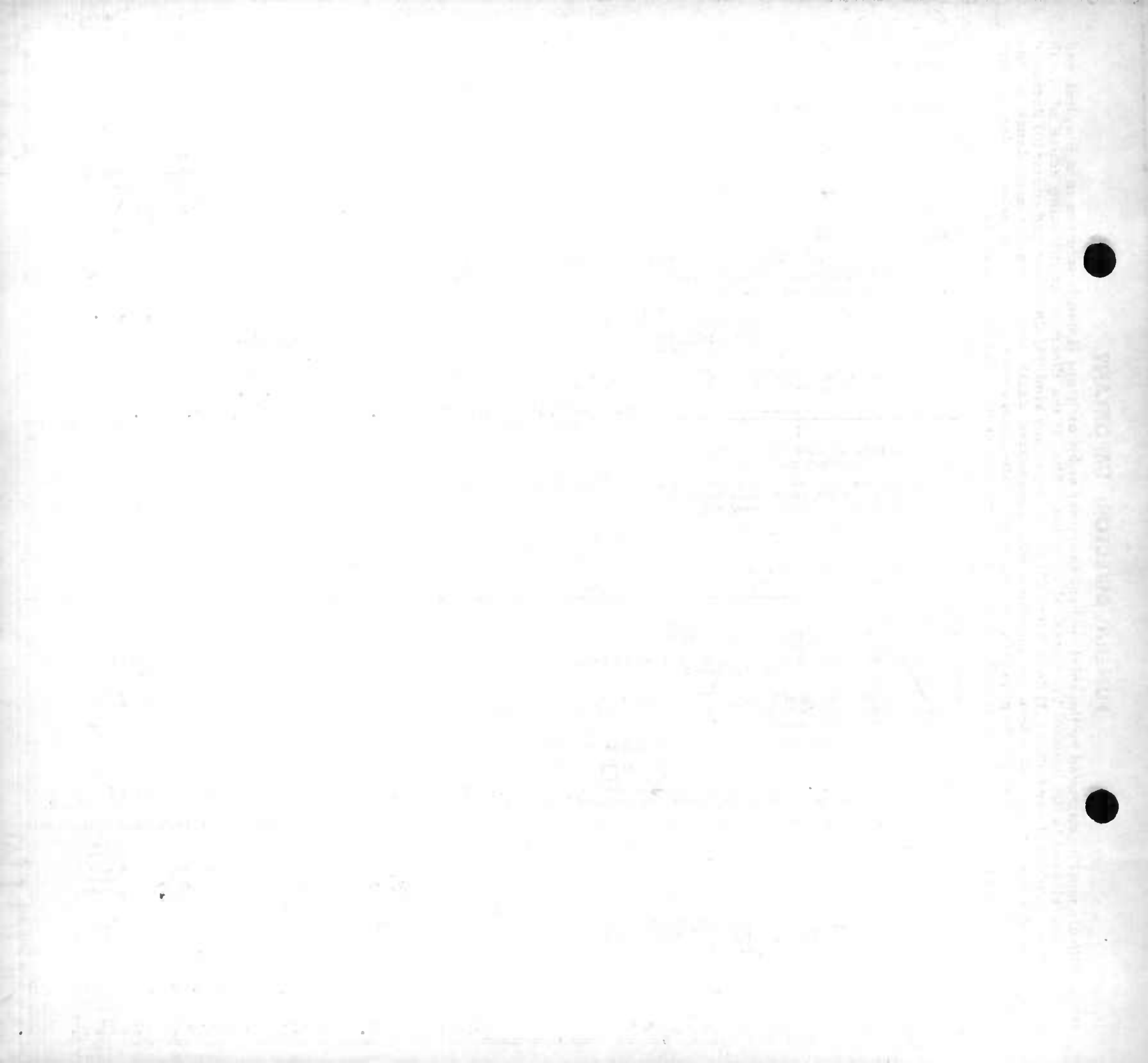
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4386	
X-40 BIRTH NO.		71 4386		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) KOLBE, WILLIAM			2. DATE AND HOUR OF DEATH MAY 3, 1971 6:15P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2005		
			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 2677 FREDERICK AVE		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 06 02 03	9. AGE (In years last birthday) 67	11. BIRTHPLACE (State or foreign country) MARYLAND
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR			10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME WILLIAM KOLBE			14. MOTHER'S MAIDEN NAME ANNIE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214030741		17. INFORMANT ADDRESS ST AGNES RECORDS WILKENS & CATON AVES	
18. 4109 I CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiogenic shock (B) Acute MI. DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from APRIL 27 19 71 to MAY 3 19 71 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on MAY 3 19 71 and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE Ching Hui Tsai, M.D.				23B. DATE SIGNED 5/3/71	
23C. PHYSICIAN'S NAME (Type) Ching-Hui Tsai, M.D.				23D. ADDRESS St Agnes Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/6/71		24C. NAME of CEMETERY or CREMATORY Mt Olivet Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 6 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS J Ambrose 1328 Sulphur Spring Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-000 71 4387				BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 71 4387	
BIRTH NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
				Type or Print <u>FRANCIS BAY</u> <u>Frances Isabella Bay</u>		<u>9:15 AM 5/4/71</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY	
<u>33</u> <u>The Johns Hopkins Hospital</u>				<u>Maryland</u>		<u>Harford</u>	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				<u>Belair</u>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER			
				<u>801 Baltimore Pike, POBox 636</u>			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
<u>Female</u>	<u>White</u>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<u>5/22/1925</u>		<u>45</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>Presser</u>			<u>Clothing</u>		<u>Maryland</u>		<u>U.S.A.</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Brackins</u> <u>George</u> BRACKINS				<u>Caudill</u> <u>Stella</u> CARDILL			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
<u>No</u>				<u>219-12-7668</u>		<u>P.O. Box 636</u> <u>Charles W. Bay</u> <u>Bel Air, Md. 21014</u>	
18. <u>430.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>SUBARACNEAN HEMORRHAGE</u> DUE TO, OR AS A CONSEQUENCE OF:			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
<u>2-28-71</u>		<u>POSS. ACUTE ENDOCERITIS</u>		<u>YES</u>		<u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, fam., factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
<u>NO</u>		<u>N/A</u>		<u>N/A</u>			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
<u>N/A</u>		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<u>N/A</u>			
22. I certify that (1) (this hospital) attended the deceased from <u>5/3/71 6:00 PM</u> 19 <u>70</u> to <u>5/4/71 9 AM</u> 19 <u>71</u> that (1) <u>last</u> saw the deceased alive on <u>5/4/71</u> 19 <u>71</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (1) <u>did</u> (did) <u>not</u> view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
<u>Bruce Northrup</u>				<u>5/4/71</u>			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
<u>BRUCE NORTHRUP MD</u>				<u>801 N. PRODDER</u> <u>BALTIMORE, MD</u>			
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5/7/1971</u>		<u>Bethel</u>		<u>Madonna, Harford, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
<u>5/6/71</u>		<u>Charles E. Kurtz</u>		<u>21084 Jarrettsville, Md.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71</u> <u>4388</u>	
BIRTH NO. <u>B-620</u>		71 <u>4388</u>			
1. NAME OF DECEASED (Type or Print) <u>Mr. Stokely L. Brooks, Sr.</u>			2. DATE AND HOUR OF DEATH <u>May 3, 1971</u> <u>2:00 AM</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1307</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>4101 Roland Ave</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>4101 Roland Ave</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/3/89</u>	9. AGE (In years last birthday) <u>83</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Sales Reliable Stores Corp.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Stores Corp.</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>James Brooks</u>			
14. MOTHER'S MAIDEN NAME <u>Molly Harefield</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>216-09-0912</u>			
16. SOCIAL SECURITY NO. <u>216-09-0912</u>		17. INFORMANT ADDRESS <u>Mrs. S. L. Brooks, Sr 4101 Roalnd Ave</u>			
18. <u>230171</u> CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Coronary occlusion</u>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Hypertensive arteriosclerotic heart disease</u> <u>Diabetes Mellitus</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>D</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>6-19-70</u> 19__ to <u>19</u> 19__ that (I) (we) last saw the deceased alive on <u>Dec. 8</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Marcio M. Menendez</u>			23B. DATE SIGNED <u>5-4-71</u>		
23C. PHYSICIAN'S NAME (Type) <u>MARCIO M. MENENDEZ, MD</u>			23D. ADDRESS <u>5820 York Rd - 81212</u>		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>5/5/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Memo. Gds</u>	
24D. LOCATION (City, town, or county) (State) <u>Timonium, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 6 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, R.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Mitchell-Wiedefeld Home 6500 York Rd.</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

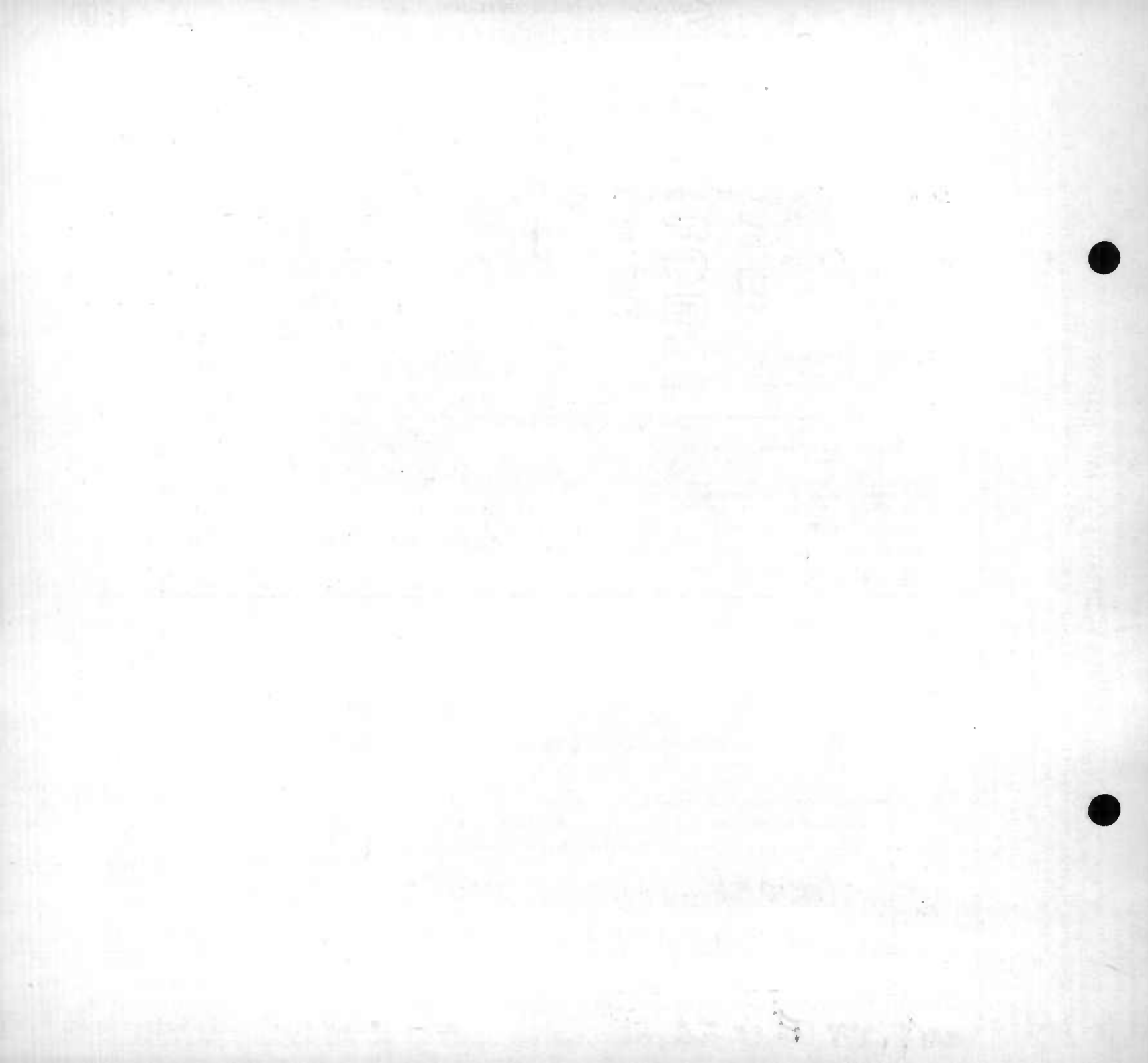
B-652 71 4389		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Charles Robert Bernscheine</u>		2. DATE AND HOUR OF DEATH <u>5/4/71</u> <u>11:10 P</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Maryland General Hospital</u> <u>48</u> <u>5-24-71</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Balt. City</u> C. CITY OR TOWN <u>Balt.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3944 Brooklyn Ave.</u>	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/17/23</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>C & C telephone Co. Supervisor</u>		9. AGE (In years last birthday) <u>47</u>	11. BIRTHPLACE (State or foreign country) <u>Balt. MD</u>
13. FATHER'S NAME <u>FRANZ Bernscheine</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>yes</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Ballantine</u>	
16. SOCIAL SECURITY NO. <u>212-26-810</u>		17. INFORMANT <u>Wife</u> ADDRESS _____	
18. <u>189.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH S.S.#215-18-0656 (A) IMMEDIATE CAUSE <u>Cachexia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>General Metastasis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Renal Cell CA</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 months</u>			
19A. DATE OF OPERATION <u>5/4</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (necly medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from <u>4/20</u> 19 <u>71</u> to <u>5/4</u> 19 <u>71</u> that (I) (we) lost saw the deceased alive on <u>5/4</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>George C. Samaras MD</u> DEGREE _____		23B. DATE SIGNED <u>5/4/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>George C. Samaras</u> DEGREE _____		23D. ADDRESS <u>Maryland General Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>B</u>	24B. DATE <u>5/8/71</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore</u>
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 6 1971</u>		25B. NAME OF REGISTRAR <u>John E. Kelly, Jr.</u>	
25C. FUNERAL DIRECTOR <u>McCurry - 737</u>		ADDRESS <u>PATRISSON CH</u>	

S.S. Card for Deceased and Widow's Affidavit
5-24-71 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4390	
<div style="font-size: 2em; font-weight: bold;">M-460 71 4390</div>				<div style="font-size: 1.5em; font-weight: bold;">CERTIFICATE OF DEATH</div>	
1. NAME OF DECEASED (Type or Print) Ruth E. Miller			2. DATE AND HOUR OF DEATH April 30, 1971		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 2833		
FULL NAME OF HOSPITAL OR INSTITUTION 00 (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2108 Tucker Lane Apt. A-8 Wakefield Apts.			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Female			6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic			10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH August 27, 1901
13. FATHER'S NAME Spencer Hairston			14. MOTHER'S MAIDEN NAME Marion ?		9. AGE (in years last birthday) 69 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 220-20-3194A		17. INFORMANT Mrs. Vonzella Murray -2108 Tucker Lane
18. 42491 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE Pulmonary edema - Cardiac Valvular disease DUE TO, OR AS A CONSEQUENCE OF: (B) Cardiac Valvular disease DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr 20 yrs
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Cardiomyopathy					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 1971 to 4/30 1971 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour one from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Edward O. Hunt Jr.				23B. DATE SIGNED 5/1/71	
23C. PHYSICIAN'S NAME (Type) Edward O. Hunt Jr. M.D.				23D. ADDRESS 2300 Garrison Blvd	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-4-71		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park	
24D. LOCATION Baltimore		24E. (City, town, or county)		24F. (State) Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 8 1971		25B. NAME OF REGISTRAR R. E. & E. E. E.		25C. FUNERAL DIRECTOR Mary-Elizabeth Law	
25D. ADDRESS 802 Madison Avenue					



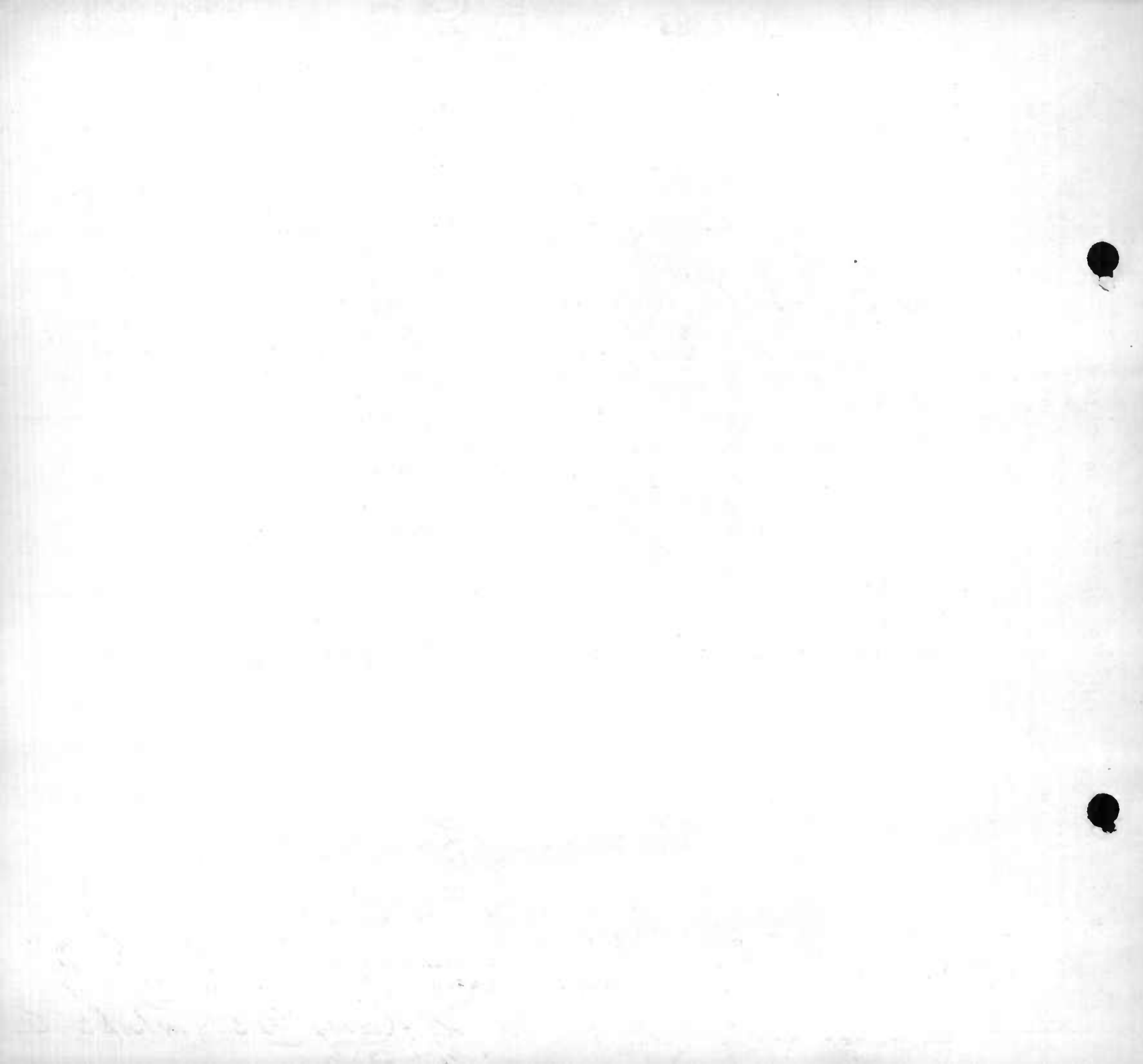
BALTIMORE CITY HEALTH DEPARTMENT			
W-252		REG. NO. 71 4391	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
THEODORE WASHINGTON		Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		3. DATE PRONOUNCED DEAD	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Month Day Year Hour	
00 518 Baker Street		April 30, 1971 7:35 A.M.	
6. SEX		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
Male		A. STATE B. COUNTY	
7. RACE		C. CITY OR TOWN	
Negro		Baltimore	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS?	
Single		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH		E. STREET AND NUMBER	
10. AGE (In years lost birthday)		518 Baker Street	
9-6-03 67			
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
White Hall, Maryland		U. S. A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		13. FATHER'S NAME	
Groom		Columbus Washington	
14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME	
		Winnie Ann Waters	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
No		300-14-9675	
18. INFORMANT		ADDRESS	
Mr. Benjamin Washington		708 N. Arlington Ave.	
19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		Carcinoma of Prostate	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		21. AUTOPSY? (Yes or No)	
20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED	
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER	
Werner U. Spitz, M.D.		ASSOCIATE MEDICAL EXAMINER	
Deputy Chief Medical Examiner		DATE SIGNED	
4/30/71			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Burial		5-5-71	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Arbutus Memorial Park		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
MAY 6 1971		Mary-Elizabeth Law	
25C. FUNERAL DIRECTOR		ADDRESS	
802 Madison Avenue			

WALTER POLICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4392	
M-225 71 4392 CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) Leona E. McGuigan		2. DATE AND HOUR OF DEATH 5/3/71			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY ANNE			
FULL NAME OF HOSPITAL OR INSTITUTION 43 S. 13 St.		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 120 Old River Road			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-6-20	9. AGE (In years last birthday) 51	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Wm E. Green			
14. MOTHER'S MAIDEN NAME Charlotte Bace		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Family - Same		ADDRESS			
18. 410.91 + 2509 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial infarction (B) Coronary atherosclerosis & diabetes DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan. 1961 to April 1971 , that (I) (we) last saw the deceased alive on April 16 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Eugene Schnitzer		23B. DATE SIGNED 5-5-71			
23C. PHYSICIAN'S NAME (Type) EUGENE SCHNITZER, M.D.		23D. ADDRESS 3904 S. Harrower St. Balt. Md. 21225			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 5/7/71		24C. NAME OF CEMETERY OR CREMATORY Holy Cross	
24D. LOCATION Balt.					
25A. DATE REC'D BY HEALTH DEPT. MAY 6 1971		25B. NAME OF REGISTRAR John E. Fisher, M.D.		25C. FUNERAL DIRECTOR W. J. Kelly - 237 W. 1st St. Balt.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4393	
C-400 71 4393				BIRTH NO.	
1. NAME OF DECEASED (Type or Print) William Cole				2. DATE AND HOUR OF DEATH May 1, 1971 11:25 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital, Inc. 2600 Liberty Heights Avenue Baltimore, Maryland 21215				A. STATE Maryland B. COUNTY St. Marys C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER Granda Nursing Home	
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-19-00	9. AGE (in years last birthday) 70	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME U. S. A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 219-54-3519		17. INFORMANT William Cole Brother ADDRESS Newberry Md.
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Acute Pulmonary edema 1 day ASHD Chronic brain syndrome					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-30-71 to 4 5-1-71 19 that (I) (we) last saw the deceased alive on 5-1-71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE Dr. Veniedo				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) DR. VENIEDO ACIDIO				23D. ADDRESS 2600 Liberty Hgts Ave 21215	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 5-6-71		24C. NAME OF CEMETERY OR CREMATORY	
25A. DATE REC'D BY HEALTH DEPT. MAY 6 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FULL NAME OF FUNERAL HOME	

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCHD

3/20/70 adm.

chapico, md.

John Henry Hefner
Baltimore, Maryland 21217

Standard Mutual Fund

70

11-18-60

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Wario

Mail

unemployed

Baltimore, Maryland

2 6-24-2219 William Cole Brother

11-1-71

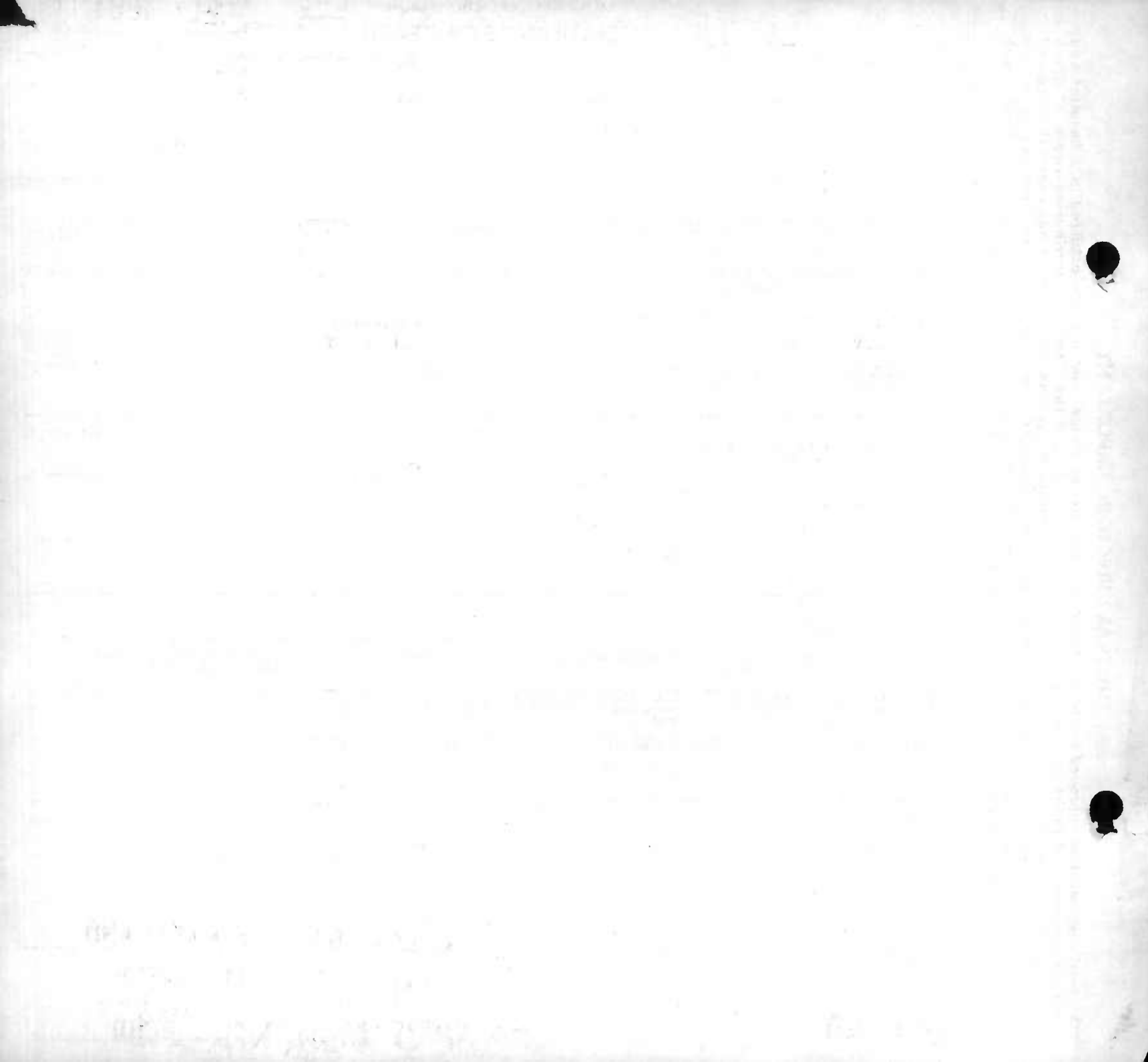
11-30-71

11-1-71

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 171 4384				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 4384	
1. NAME OF DECEASED (Type or Print) MORRIS CLEVELAND				2. DATE AND HOUR OF DEATH 4/27/71 3:30 PM					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution residence before admission) A. STATE MD. B. COUNTY BALTIMORE					
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL BALTIMORE, MD.				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 934 McDONOUGH STREET				5. SEX MALE		6. RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1/20/32				9. AGE (In years last birthday) 39		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME CLEVELAND		14. MOTHER'S MAIDEN NAME PAULINE DYSON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. 482.10 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE Klebsiella pneumoniae DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/25 19 71 to 4/27 19 71 that (I) (we) last saw the deceased alive on 4/27 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				23A. SIGNATURE David Driscoll MD					
23C. PHYSICIAN'S NAME (Type) DAVID DRISCOLL, MD				23D. ADDRESS JOHNS HOPKINS HOSPITAL		23E. DATE SIGNED 4/27/71		23F. DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE 5-6-71		24C. NAME of CEMETERY or CREMATOR		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. MAY 6 1971				25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR		25D. ADDRESS	
VS 150-REV. 1/1/68				ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCRD					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4395	
G-500 71 4395				BIRTH NO.	
1. NAME OF DECEASED (Type or Print) Wiley Guin			2. DATE AND HOUR OF DEATH 5/1/71 7:00 P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 37 Mercy Hospital, Inc.			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2201		
FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital, Inc.			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 702 Williams St. #21230		
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-05-22	9. AGE (In years last birthday) 48	II Under 1 Tr. II Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
18. 410.91 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute MI ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/1/71 to 5/1/71 that (I) (we) last saw the deceased alive on 5/1/71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ky1 K LWIN MD			23B. DATE SIGNED 5/2/71		23C. PHYSICIAN'S NAME (Type)
24A. BURIAL CREMATION, REMOVAL (Specify)			24B. DATE 5-6-71		24C. NAME OF CEMETERY or CREMATOR
25A. DATE REC'D BY HEALTH DEPT.			25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE

FUNERAL DIRECTOR: IMPORTANT

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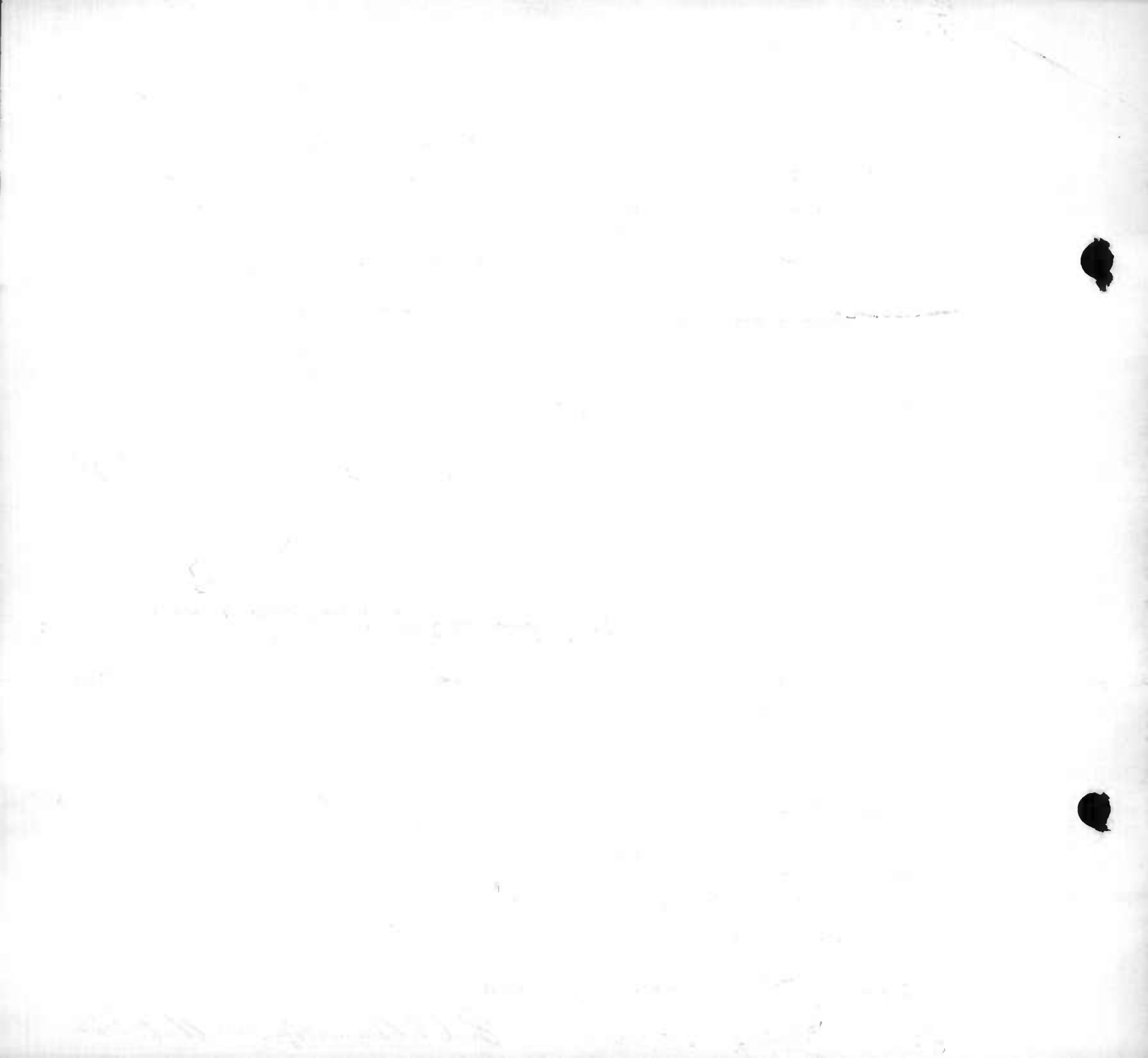
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 4396</u>
BIRTH NO. <u>P-412 71 4396</u>		1. NAME OF DECEASED (Type or Print) <u>FRANK L PHILLIPS</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <u>4-29-71 14:40 P.M.</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Med. Gen. Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1102</u>		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER				
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-29-29</u>	9. AGE (In years last birthday) <u>81</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
18. <u>4124 I</u> CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 min.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiac Arrest</u>	
			(B) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF: <u>yes</u>	
			(C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (the hospital) attended the deceased from <u>10-2</u> 19 <u>70</u> to <u>12-16</u> 19 <u>70</u> that (I) (we) last saw the deceased alive on <u>12-15</u> 19 <u>70</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.				
23A. SIGNATURE <u>Frank F. Kuehn</u>		23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) <u>FRANK F. KUEHN</u>		23D. ADDRESS <u>ANATOMY BOARD OF MARYLAND</u>		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>5-6-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>UNIVERSITY MEDICAL SCHOOL</u>
24D. LOCATION (City, town, & county) (State)		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 6 1971</u>		
25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCHO</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-520 71 4397		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 4397	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>JAMES W. THOMAS</u>		2. DATE AND HOUR OF DEATH <u>5-4-71</u> <u>9:55 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTO.</u>		5. CITY OR TOWN <u>BALTO.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>4800 D. Gen. Hosp.</u> <u>827 LINCOLN AVE</u>		E. STREET AND NUMBER <u>457 W 24th St.</u> <u>21211</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-2-02</u>	9. AGE (in years last birthday) <u>69</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mod. MGR</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>SUPERMARKET</u>		11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-162979</u>		17. INFORMANT <u>?</u>	
18. CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>BRONCHOGENIC CARCINOMA</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>BRONCHOGENIC CARCINOMA</u>			
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>CA 2 pancreas; pulmonary emphysema; bronchiectasis & chr. pneumonia</u>		19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (This hospital) attended the deceased from <u>4-20-71</u> to <u>5-4-71</u> that (I) (we) lost saw the deceased alive on <u>5-4-71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>L. A. Courtney M.D.</u>		23B. DATE SIGNED <u>5-4-71</u>			
23C. PHYSICIAN'S NAME (Type) <u>L. A. COURTNEY M.D.</u>		23D. ADDRESS <u>827 LINCOLN AVE</u> <u>21201</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>5-7-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>LORRANE PARK</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTO MD</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 7 1971</u>		25B. NAME OF REGISTRAR <u>Paul E. Schenck</u>	
25C. FUNERAL DIRECTOR <u>Paul E. Schenck</u>		25D. ADDRESS <u>3615 Chestnut Ave.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>71 4398</u>	
<u>U-600</u> BIRTH NO. <u>71 4398</u>		1. NAME OF DECEASED (Type or Print) <u>WHARRY, WILLIAM FREDERICK, SR.</u>		2. DATE AND HOUR OF DEATH <u>MAY 2, 1971</u> <u>7:00 P</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>40 ST. AGNES HOSPITAL</u> <u>CATON & WILKENS AVE</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> ANNE ARUNDEL <u>5200</u> C. CITY OR TOWN <u>LINTHICUM HEIGHTS</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>703 EVELYN AVENUE</u> <u>21090</u>			
5. SEX <u>MALE</u>		6. RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>06 08 98</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>SELF EMPLOYED</u>		9. AGE (In years last birthday) <u>72</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>George M. Wharry</u>				14. MOTHER'S MAIDEN NAME <u>Mary B. Noghoff</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217 07 5665</u>		17. INFORMANT <u>WILKENS AVE BALTO MD. 21229</u> <u>ST AGNES HOSPITAL RECORDS CATON &</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>4-10-71</u> <u>acute myocardial infarction</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:		(C)	
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>MAY 2 1971</u> to <u>MAY 2 1971</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>MAY 2 1971</u> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>W.K. Gallagher, Jr. M.D.</u>				23B. DATE SIGNED <u>05 02 71</u>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <u>WILMER K. GALLAGER JR. M.D.</u>				23D. ADDRESS <u>WILKENS & PINE BEIGHTS AVE</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-5-1971</u>		24C. NAME of CEMETERY or CREMATORY <u>St. Paul's Lutheran Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Violetville, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 7 1971</u>				25B. NAME OF REGISTRAR <u>Howard H. Hubbard</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>	

THE UNITED STATES OF AMERICA

DEPARTMENT OF THE ARMY
WASHINGTON, D. C.

OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, D. C.

TO THE SECRETARY OF THE ARMY

FROM

DATE

1944

RE: [illegible]

[illegible]

1. [illegible]

[illegible]

2. [illegible]

3. [illegible]

4. [illegible]

[illegible]

[illegible]

~

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

[illegible signature]

11. [illegible]

12. [illegible]

13. [illegible]

14. [illegible]

15. [illegible]

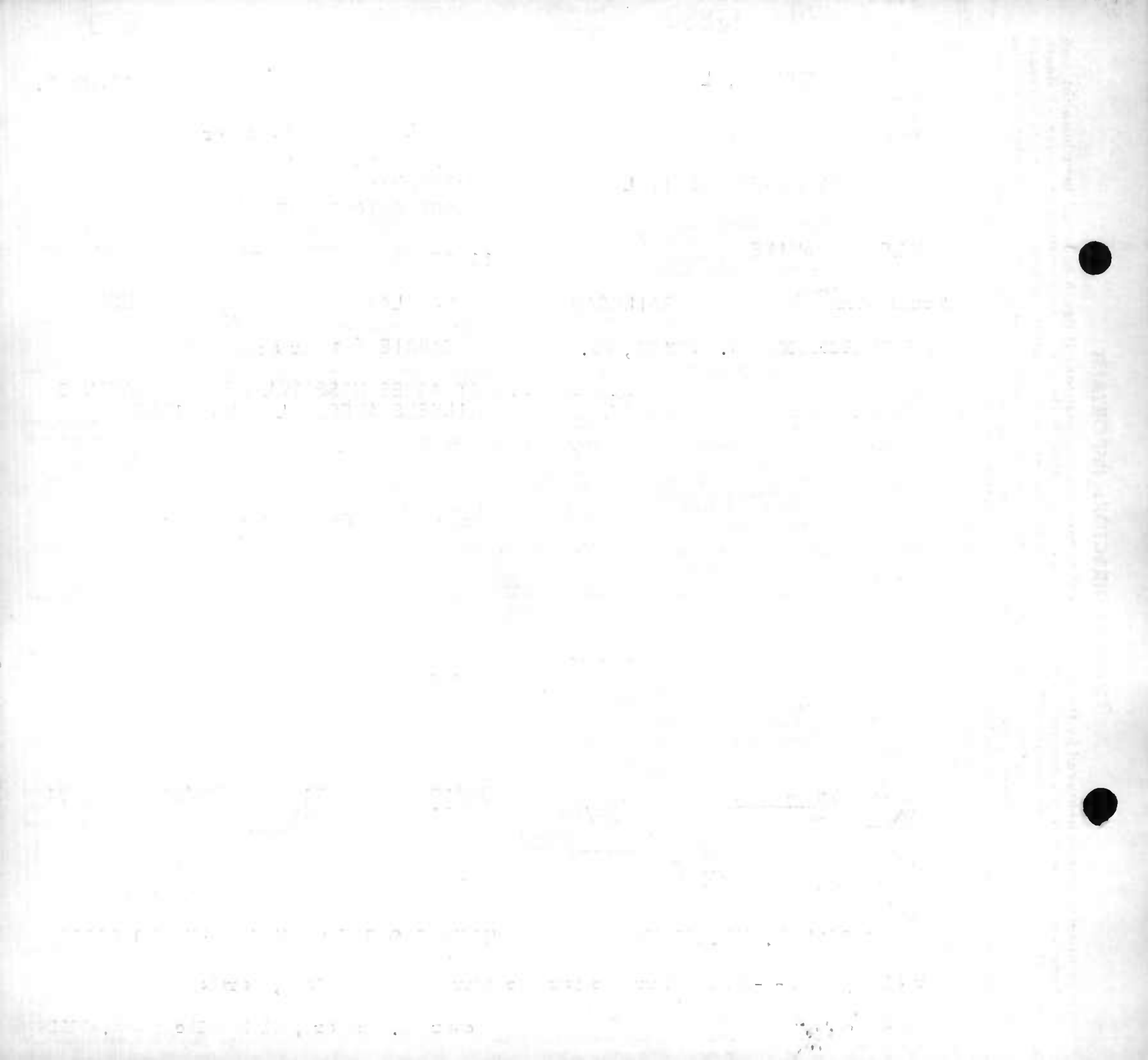
16. [illegible]

17. [illegible]

18. [illegible]

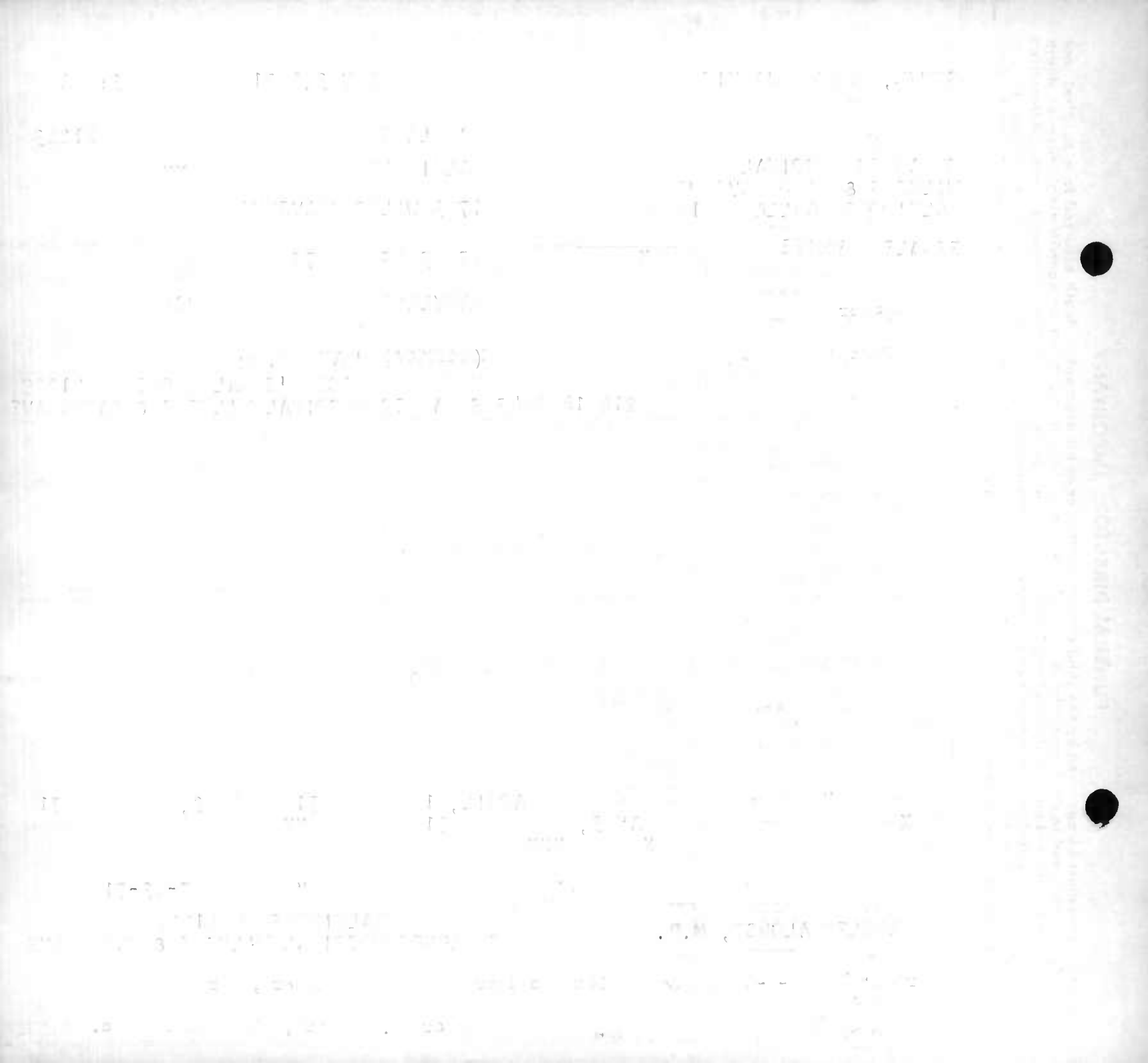
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4399	
<div style="display: flex; justify-content: space-between;"> S-536 71 4399 CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		SNYDER, LOUIS		05 03 71 12:04 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
40 ST AGNES HOSPITAL			MARYLAND Baltimore		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			BALTIMORE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER		
			3206 BRYANT AVENUE		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11 27 00	70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Tarrif Clerk		RAILROAD		MARYLAND	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
HENRY SNYDER W. SNYDER, SR.			CARRIE (Gubernatis)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		705 05 5418		ST AGNES HOSPITAL RECORDS CATON & WILKENS AVES BALTO MD 21229	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES			upper Gastrointestinal Bleeding		3 hrs
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
			Chronic Obstructive Pulmonary Disease		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that <u>XX</u> (this hospital) attended the deceased from <u>04/19</u> 19 <u>71</u> to <u>05/03</u> 19 <u>71</u> that <u>XX</u> (we) last saw the deceased alive on <u>05/03</u> 19 <u>71</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>X</u> (We) (did) <u>XXXX</u> view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Joseph H. Miller, MD				5/3/71	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
JOSEPH H. MILLER MD				WILKENS & CATON AVES BALTO MD 21229	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		5-6-1971		Lorraine Park Cemetery	
				24D. LOCATION (City, town, or county) (State)	
				Woodlawn, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAY 7 1971		R. E. Miller, Jr.		Howard H. Hubbard, 4107 Wilkens Ave. 21229	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. S-365 71 4400				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 4400	
1. NAME OF DECEASED STURM, MAYO JARVIS				2. DATE AND HOUR OF DEATH MARY 3, 1971		3:00A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL WILKENS & CATON AVENUES BALTIMORE MARYLAND 21229				A. STATE MARYLAND		B. COUNTY 21223	
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1723 WILKENS AVENUE		1903	
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 05 05 95	
				9. AGE (In years lost birthday) 75		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
						12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Kemp				14. MOTHER'S MAIDEN NAME XXXXXXXXXX URATH LANT			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 214 14 8945		17. INFORMANT RECORD'S BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH Infiltrating ductal carcinoma (B) breast (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) ASCVD: congestive (C) heart failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from APRIL 10, 1971 to MAY 3, 1971 that (X) (we) last saw the deceased alive on MAY 3, 1971 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (dXXX) view the body after death.							
23A. SIGNATURE Adolfo Alonso				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 05-03-71	
23C. PHYSICIAN'S NAME (Typed) ADOLFO ALONSO, M.D.				23D. ADDRESS BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-6-1971		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 7 1971				25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 4401</u>	
BIRTH NO. <u>H-400 71 4401</u>		1. NAME OF DECEASED (Type or Print) <u>Nadia S. Hill</u>			
2. DATE AND HOUR OF DEATH <u>May 3, 1971 7⁰⁰ A.M.</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Bon Secours Hospital.</u>			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>XXXXXX</u>		5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Bon Secours Hospital.</u>			
C. CITY OR TOWN <u>Balto.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <u>516 Lucia Ave.</u>					
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-17-86</u>	9. AGE (In years last birthday) <u>85</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>XXXXXX Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Harp</u>			
14. MOTHER'S MAIDEN NAME <u>Polly Ann Francis</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>212543034</u>		17. INFORMANT ADDRESS <u>Mrs. Jessie M. Biddinger, 516 Lucia Ave. 21229</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>AscVD CHF, Malnutrition & dehydration</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>secondary anemia</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>chronic thorachitis and bronchitis</u> DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>4/2/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/2/71</u> 19 <u>71</u> to <u>5/3/71</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>5/2</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Ferdous Kazemi</u>				23B. DATE SIGNED <u>5/3/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Kazemi</u>				23D. ADDRESS <u>Bon Secours Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-5-1971</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>	
24D. LOCATION <u>GlenBurnie, Anne Arundel Co., Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 7 1971</u>			
25B. NAME OF REGISTRAR <u>Robert L. Hubert, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>			

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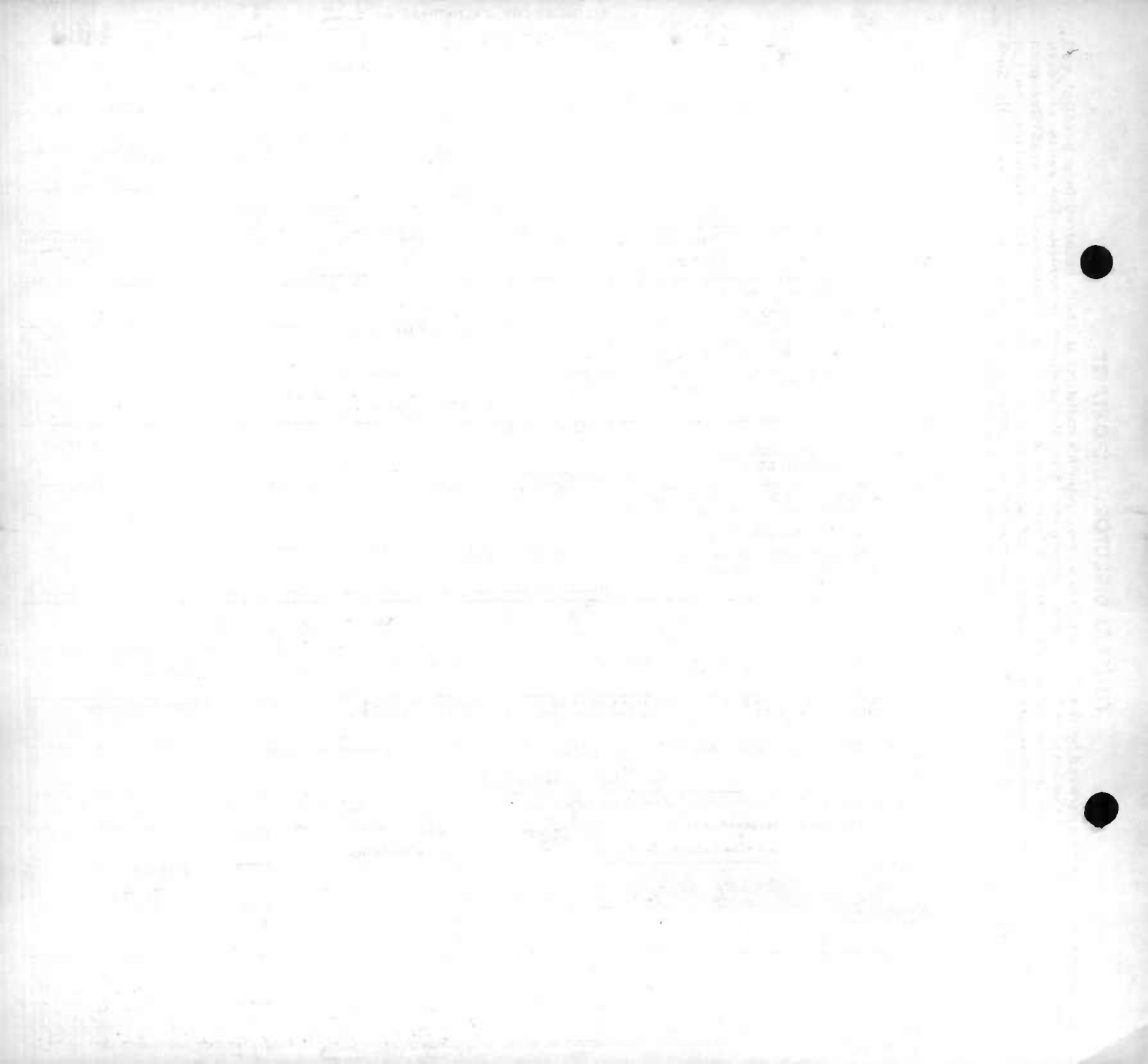
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

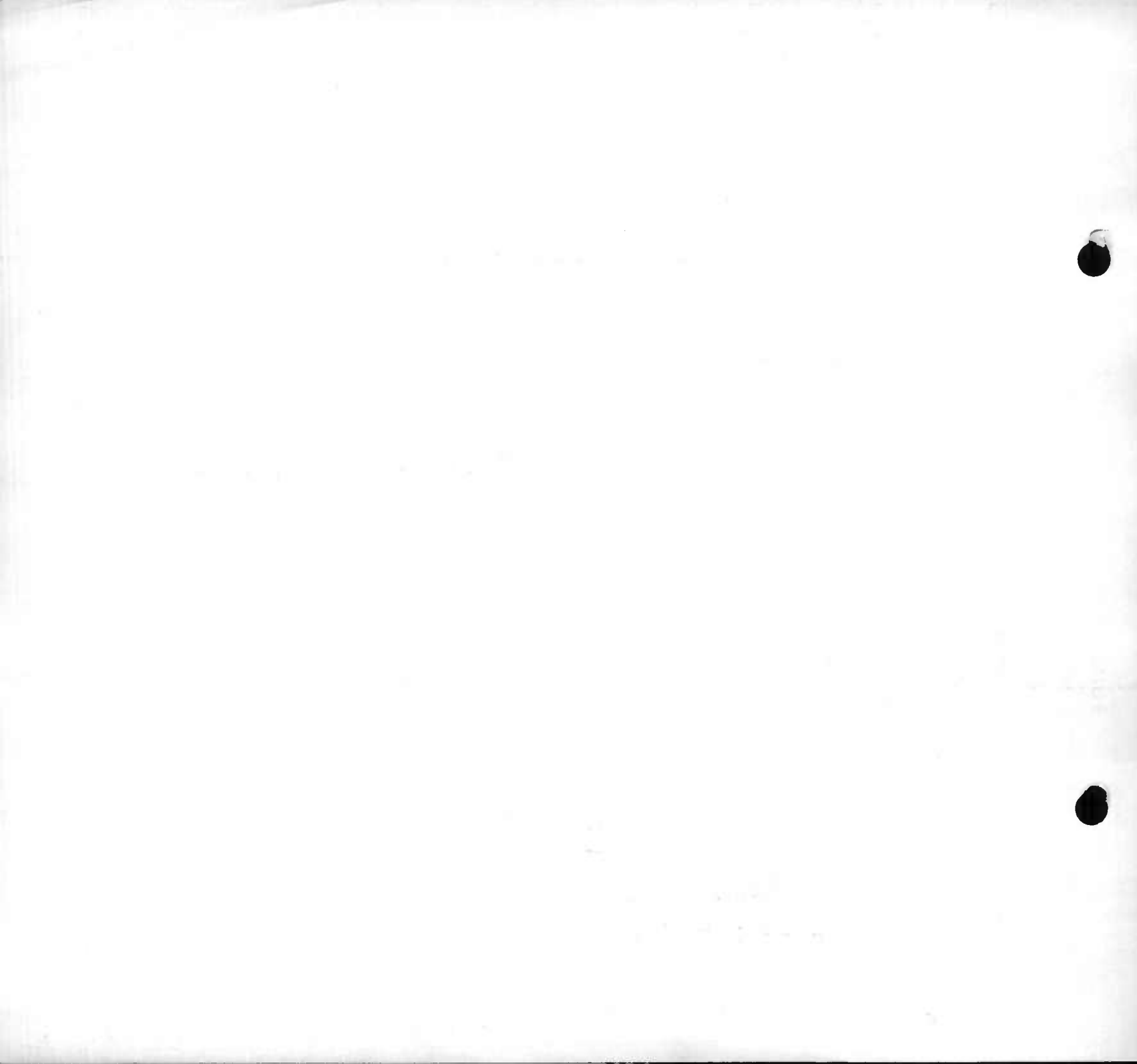
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. <u>4-625 71-05529 4402</u>					REG. NO. <u>71 4402</u>				
1. NAME OF DECEASED (Type or Print) <u>THOMAS HAIRSINE JR.</u>					2. DATE AND HOUR OF DEATH <u>5/3/71</u> <u>8:10 P</u> M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS HOSPITAL</u> <u>33</u>					A. STATE <u>BALT</u> B. COUNTY <u>Maryland</u>				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				
					E. STREET AND NUMBER <u>3421 Chestnut Avenue</u>				
5. SEX <u>MALE</u>	6. RACE <u>CAUC.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>3/22/71</u>	9. AGE (in years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			<u>Infant-None</u>	<u>MD</u>	<u>USA</u>	<u>THOMAS J HAIRSINE SR</u>	<u>Edwina Phillips</u>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>					16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Thomas J Hairsine Jr</u>		
18. <u>7469 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Congenital Heart Disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>---</u>				
19. DATE OF OPERATION <u>---</u>					20. AUTOPSY? (Yes or No) <u>YES</u>				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (H) (this hospital) attended the deceased from <u>April 17</u> 19 <u>71</u> to <u>May 3</u> 19 <u>71</u> that (H) (we) lost saw the deceased alive on <u>May 3</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					23A. SIGNATURE <u>Alan A Fields MD</u> DEGREE				
23B. DATE SIGNED <u>5/3/71</u>					23C. PHYSICIAN'S NAME (Type) <u>ALAN J. FIELDS</u> DEGREE				
23D. ADDRESS <u>601 N. BROADWAY BALT MD</u>					24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				
24B. DATE <u>5-7-71</u>					24C. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem</u>				
24D. LOCATION <u>Woodlawn Bldg Co Md</u>					25A. DATE REC'D BY HEALTH DEPT. <u>MAY 7 1971</u>				
25B. NAME OF REGISTRAR <u>Burger Funeral Home</u>					25C. FUNERAL DIRECTOR <u>Burger Funeral Home</u>				
25D. ADDRESS <u>B4 Wilson Avenue</u>									



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

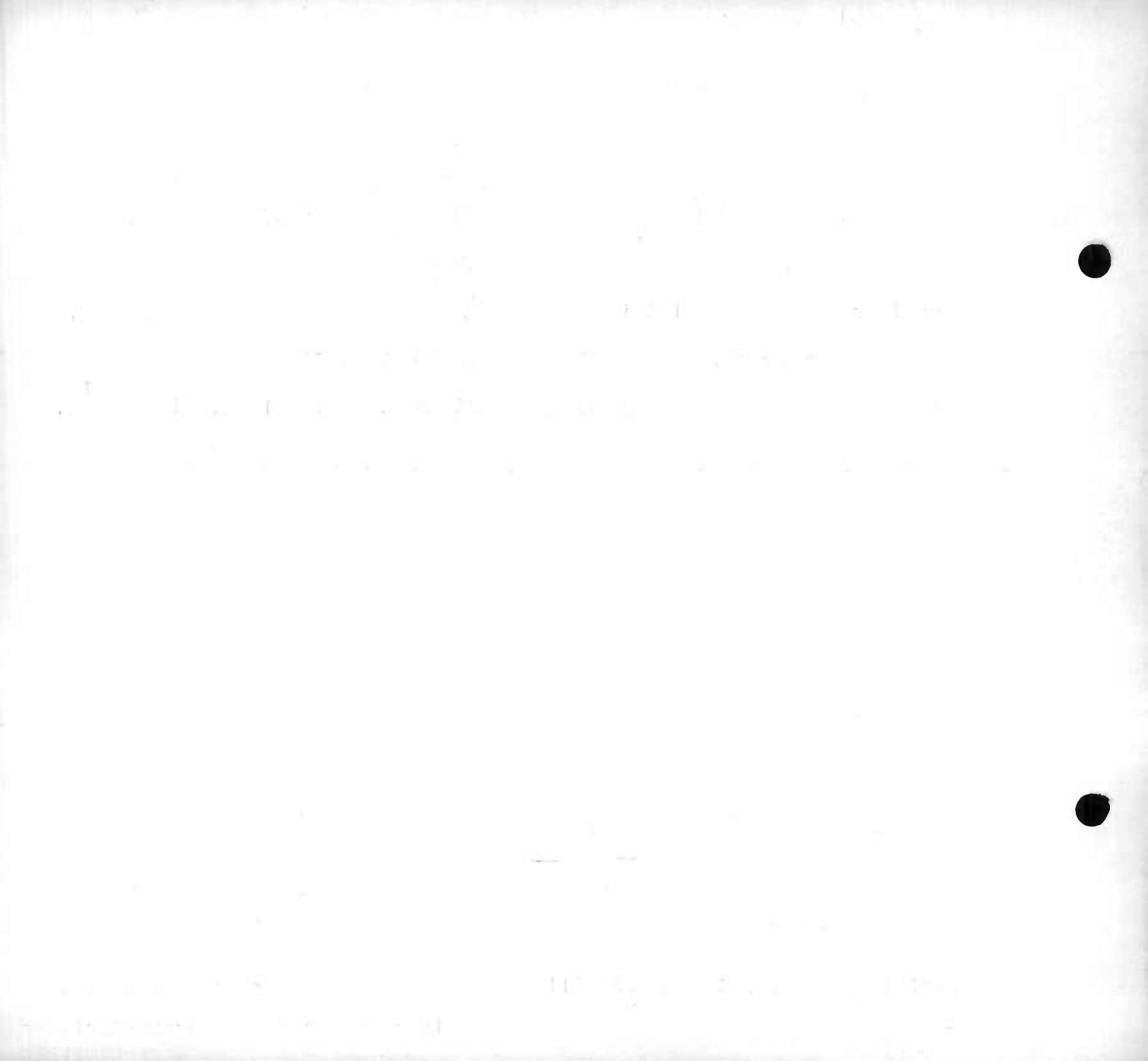
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 4403</u>	
BIRTH NO. <u>11-625 71 4403</u> 1. NAME OF DECEASED (Type or Print) <u>Thomas F. Morgan</u>		2. DATE AND HOUR OF DEATH <u>5/5/71</u> <u>6:30 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00311 Scott St.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>md</u> B. COUNTY <u>2101</u> 5. CITY OR TOWN <u>Baltimore</u> 6. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 7. STREET AND NUMBER <u>311 Scott St.</u> <u>21230</u>			
8. SEX <u>Male</u> 9. RACE <u>white</u> 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 11. WIDOWED <input type="checkbox"/> 12. DIVORCED <input type="checkbox"/>	13. DATE OF BIRTH <u>4/14/1898</u> 14. AGE (in years last birthday) <u>73</u> 15. If Under 1 Yr. Months Days 16. If Under 24 Hrs. Hours Min.		17. BIRTHPLACE (State or foreign country) <u>St. Mary's Co. Md.</u> 18. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
19. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard</u> 20. KIND OF BUSINESS OR INDUSTRY <u>Detective Agency</u>		21. FATHER'S NAME <u>Thomas Morgan</u> 22. MOTHER'S MAIDEN NAME <u>Janette Burch</u>			
23. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> 24. SOCIAL SECURITY NO. <u>216-09-2241</u>		25. INFORMANT <u>Bessie Morgan</u> 26. ADDRESS <u>311 Scott St - 21230</u>			
27. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 28. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>ARTERIO-SCLEROTIC C.V.D.</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>DIABETES MELLITUS</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		29. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>16 yrs</u> <u>16 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
30. DATE OF OPERATION <u>5-5-71</u> 31. CONDITION FOR WHICH OPERATION WAS PERFORMED		32. AUTOPSY? (Yes or No) <u>no</u> 33. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		34. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) _____ 35. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
36. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		37. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ 38. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		39. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from <u>1-2</u> 19<u>65</u> to <u>5-5</u> 19<u>71</u> that (I) (we) last saw the deceased alive on <u>April 2nd</u> 19<u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (We) (did not) view the body after death.					
23A. SIGNATURE <u>Harry F. Kates MD</u> 23B. DATE SIGNED <u>May 6-71</u>		23C. PHYSICIAN'S NAME (Type) <u>HARRY F. KATES MD</u> 23D. ADDRESS <u>517 Scott St. Baltimore, Md.</u>			
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u> 24B. DATE <u>5/8/71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Glen Home Co.</u> 24D. LOCATION (City, town, or county) (State) <u>Glenhome, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 7 1971</u> 25B. NAME OF REGISTRAR <u>John J. Gowan</u> 25C. FUNERAL DIRECTOR <u>John J. Gowan</u> 25D. ADDRESS <u>23 - 1st St.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 4404	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) Beulah M. Hart		2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> 5/5/71 9:20 A.M. </div>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) <div style="display: flex; justify-content: space-between;"> <div> A. STATE Md. </div> <div> B. COUNTY 1903 </div> </div> C. CITY OR TOWN Baltimore			
5. SEX F		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 5/7/00		9. AGE (In years last birthday) 70		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Examiner	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S. A.			
13. FATHER'S NAME George Fitzwater		14. MOTHER'S MAIDEN NAME Isadore Schumacher			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-22-6550		17. INFORMANT Arthur T. Hart	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <div style="text-align: center;">II</div> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH Chronic illness - ASCVD - mild CHF - coronary malnutrition - severe anemia. - basal ganglia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) acute Bronchitis DUE TO, OR AS A CONSEQUENCE OF: (C)			
19A. DATE OF OPERATION none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED none		20A. AUTOPSY? (Yes or No) none	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/28 19 71 to 5/5 19 71 that (I) (we) last saw the deceased alive on 5/5 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE F. Kazemi				23B. DATE SIGNED 5/5/71	
23C. PHYSICIAN'S NAME (Type) FERDOUS KAZEMI M.D.		23D. ADDRESS BON SECOURS Hospital Baltimore, Md. 21223			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/8/71		24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery	
24D. LOCATION (City, town, or county) (State) Anne Arundel County, Md.		25A. DATE REC'D BY HEALTH DEPT. - 25B. NAME OF REGISTRAR MAY 7 1971			
25C. FUNERAL DIRECTOR Waltons Funeral Home		25D. ADDRESS Pratt & Stricker Streets 21223			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN K. TURNER				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 34 BON SECOURS HOSPITAL				3. DATE PRONOUNCED DEAD Month Day Year Hour May 5, 1971 12:50 AM			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2551			
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 4-25-1909		10. AGE (In years last birthday) 62		E. STREET AND NUMBER 806 Primson Avenue			
11. BIRTHPLACE (State or foreign country) Colorado		12. CITIZEN OF U.S.A.		13. FATHER'S NAME Ohlie H. Turner			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer				14B. KIND OF BUSINESS OR INDUSTRY Lloyd E. Mitchell			
15. MOTHER'S MAIDEN NAME Ella May Fry				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No			
17. SOCIAL SECURITY NO. 218-01-2422				18. INFORMANT Mrs. Josephine Turner, 806 Primson Ave. 21229			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Peritonitis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE (B) Contusion of pancreas (C) Blunt force injury to abdomen				DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Streets		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Wilkins and Pulaski Street 2003			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 4-30-71 8:25 P.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Driver of auto struck parked cars			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum, M.D. M.D. EXAMINER'S NAME (Type) DATE SIGNED 5/5/71							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-8-1971		24C. NAME of CEMETERY or CREMATORY Van Sickle Cemetery		24D. LOCATION (City, town, or county) (State) Farmington, Fayette County, Pa.	
25A. DATE REC'D BY HEALTH DEPT. MAY 7 1971		25B. NAME OF REGISTRAR John E. Fisher, M.D.		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229			

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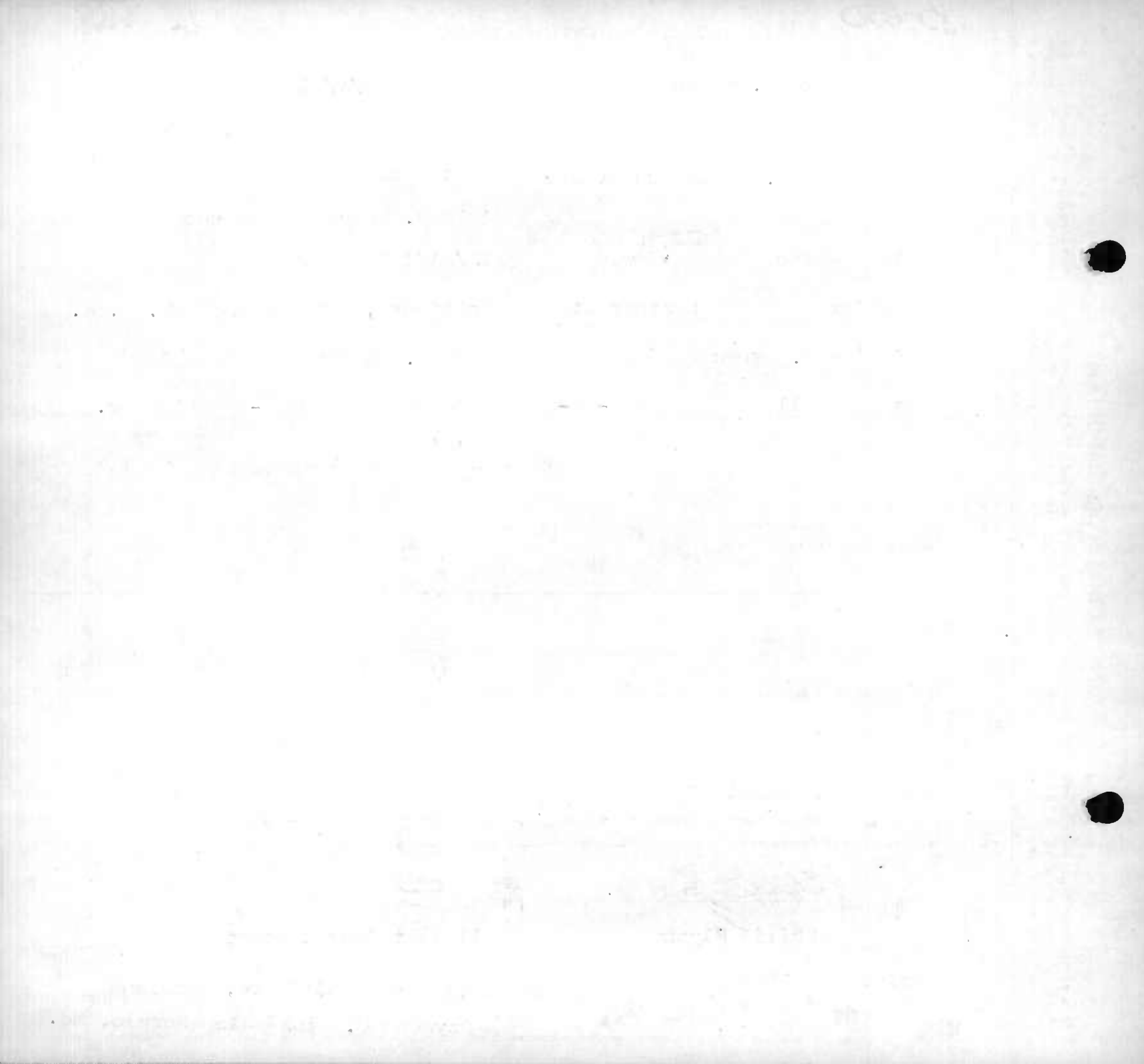
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1. NAME OF DECEASED (Type or Print) Harry Stanko		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 5 Day 2 Year 71 Hour 6:30 p. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 34 Bon Secours Hospital		3. DATE PRONOUNCED DEAD Month 5 Day 2 Year 71 Hour 6:30 p. M.	
6. SEX male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2341	
9. DATE OF BIRTH 2-4-1930		10. AGE (In years last birthday) 41	
11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Army		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates at service) Yes Korean		17. SOCIAL SECURITY NO. 169-24-2637	
18. INFORMANT Mrs. Liselotte Stanko, 706 Bethnal Rd. 21229		ADDRESS	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) E9881X Subdural hematoma		CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
II Fatty metamorphosis of liver		(C)	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) UNK	
22D. TIME OF INJURY (APPROX.) Month () Day () Year () Hour () UNK UNK m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? UNK		22F. HOW DID INJURY OCCUR? UNK	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>		21. AUTOPSY? (Yes or No) yes	
ACTUAL SIGNATURE Peter Lipkovic, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED 5/3/71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-6-1971	
24C. NAME OF CEMETERY or CREMATORY Arlington National Cemetery Fort Myers, Virginia		24D. LOCATION (City, town, or county) (State)	
25A. DATE RECEIVED BY HEALTH DEPT. MAY 7 1971		25B. NAME OF REGISTRAR Robert E. Farley, M.D.	
25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		ADDRESS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-650 BIRTH NO. 71 4407		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 71 4407	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) Edward A. Brown			2. DATE AND HOUR OF DEATH 5/4/71 M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 1829 E. Belvedere Avenue			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1829 E. Belvedere Avenue		
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 10/21/1900	9. AGE (In years last birthday) 70	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier		10B. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME William E. Brown			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 11			14. MOTHER'S MAIDEN NAME Mary G. Fanning		
16. SOCIAL SECURITY NO. 212-01-5881			17. INFORMANT Helen King 8300 -B Nunley Dr. (Sister)		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 41019 I Coronary Occlusion DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH Immediate		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5-4 1971 to 5-4 1971, that (I) (we) last saw the deceased alive on 4-27- 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Philip Flynn			23B. DATE SIGNED 5/5/71		
23C. PHYSICIAN'S NAME (Type) Philip Flynn			23D. ADDRESS 11 East Chase Street		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/7/71		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. MAY 7 1971			
25B. NAME OF REGISTRAR Raymond C. Fink		25C. FUNERAL DIRECTOR Glen Burnie, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

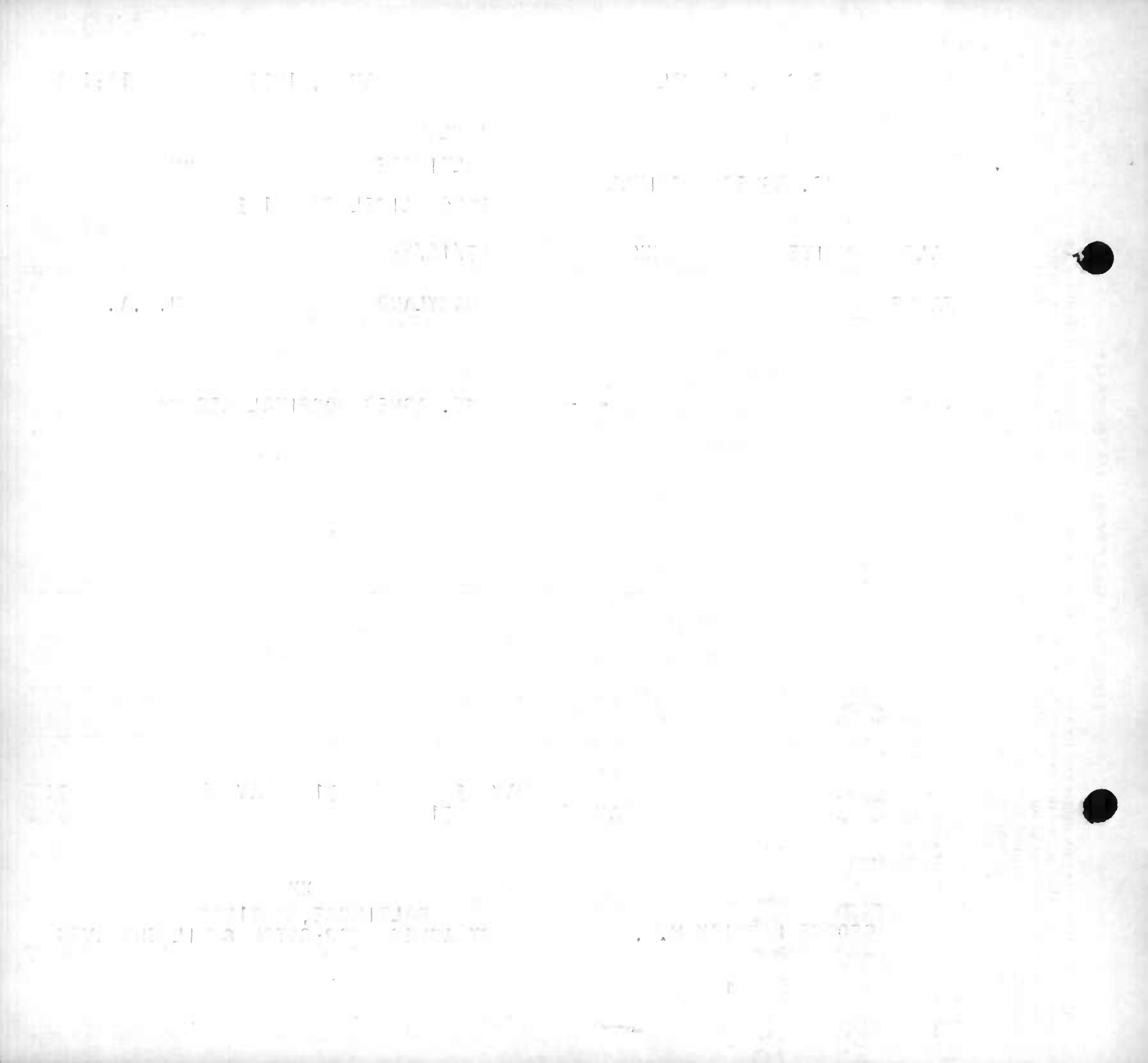
BALTIMORE CITY HEALTH DEPARTMENT				71 4408		REG. NO.	
BIRTH NO. G-635		71 4408		BALTIMORE CITY HEALTH DEPARTMENT		71 4408	
1. NAME OF DECEASED (Type or Print) Frank S. Groton				2. DATE AND HOUR OF DEATH May 4, 1971 3:30 p M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 00		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 709 Chestnut Hill Avenue Baltimore, Md. 21218		A. STATE Maryland 21218		B. COUNTY 903	
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 709 Chestnut Hill Avenue			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 10, 1903	9. AGE (in years last birthday) 68	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dispatcher		10B. KIND OF BUSINESS OR INDUSTRY Balto. Transit Co.		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Benjamin Groton				14. MOTHER'S MAIDEN NAME Lula White			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-10-2984		17. INFORMANT Kathryn S. Groton (Wife) Same			
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cancer of Liver II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerosis				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months			
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 6:15 to May 4, 1971 that (I) (we) last saw the deceased alive on May 4, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Dr. William G. Helfrich				23B. DATE SIGNED 6 May 7/		23C. PHYSICIAN'S NAME (Type) Dr. William G. Helfrich	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/7/71		24C. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 7 1971		25B. NAME OF REGISTRAR Robert E. Taylor, Md.		25C. FUNERAL DIRECTOR Eugenia K. Seitz 5209 York Road Seitz Funeral Home Balto. Md. 21212			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

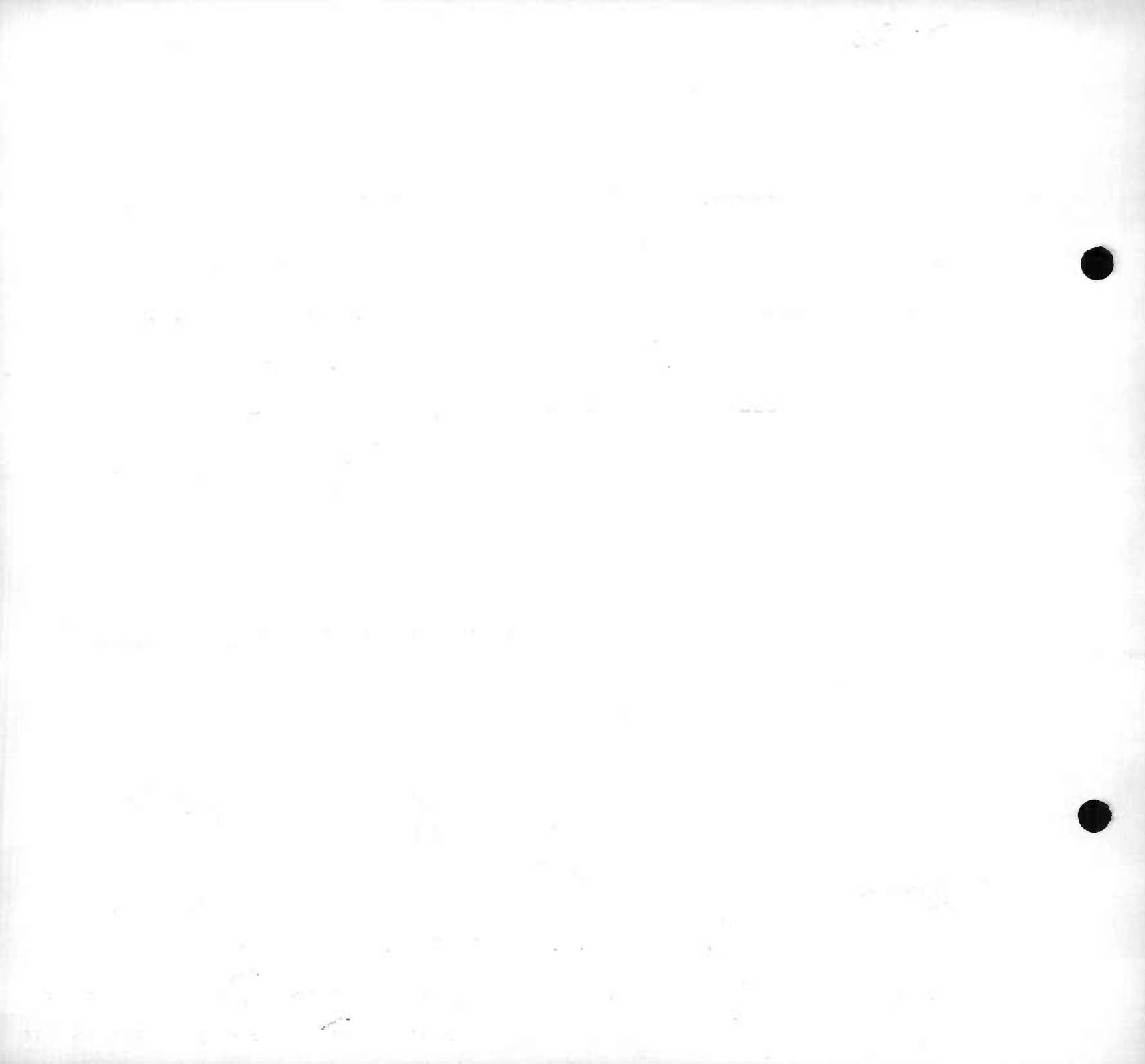
BIRTH NO. M-625 71 4408		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 4408	
1. NAME OF DECEASED (Type or Print) MERSON, SAMUEL				2. DATE AND HOUR OF DEATH MAY 4, 1971 11:10A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE MARYLAND B. COUNTY 2553 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1926 MAISEL ST 21230			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 07/16/88	9. AGE (In years last birthday) 82	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. 215-18-6097A		17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) respiratory depression ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. gcm neg shock chlamydia tract infection II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). emphysema				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from MAY 03 1971 to MAY 04 1971 that (I) (we) last saw the deceased alive on MAY 04 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE George S. Forman				23B. DATE SIGNED 5-7-71		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) GEORGE PATRICK M.D.				23D. ADDRESS BALTIMORE, MD 21229 ST AGNES HOSP; CATON & WILKENS AVES			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/6/71		24C. NAME of CEMETERY or CREMATORY Friendship Cemetery		24D. LOCATION (City, town, or county) (State) Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 7 1971				25B. NAME OF REGISTRAR John E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Witzke, 4101 Edmondson Ave., 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 4410	
BIRTH NO. S-560		1. NAME OF DECEASED (Type or Print) Guy O. Seemer		2. DATE AND HOUR OF DEATH May 4, 1971	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3944 Hickory Avenue Baltimore, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1307	
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Aug 6, 1902		9. AGE (In years last birthday) 68 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Resturant (Partner)	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Wilmer O. Seemer	
14. MOTHER'S MAIDEN NAME Birdie E. Bland		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-01-5621	
17. INFORMANT Mrs. Zella Seemer-3944 Hickory Ave.		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hrs	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) —	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Chronic Bronchitis		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) many yrs	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 8/12/60		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? 5/4/71	
22. I certify that (I) (this hospital) attended the deceased from 8/12/60 19 to 5/4/71 19 that (I) (we) last saw the deceased alive on 4/30 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]		23B. DATE SIGNED 5/5/71		23C. PHYSICIAN'S NAME (Type) William F. Renner M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE May 7, 1971		24C. NAME of CEMETERY or CREMATORY Woodlawn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 21207		25A. DATE REC'D BY HEALTH DEPT. MAY 7 1971		25B. NAME OF REGISTRAR Robert A. Sabin, M.D.	
25C. FUNERAL DIRECTOR Donovan Funeral Home		25D. ADDRESS 3818 Roland Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. S-220		71 4411		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 71 4411	
1. NAME OF DECEASED (Type or Print) JAMES SIEJACK				2. DATE AND HOUR OF DEATH 5/6/71 9:25 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 6853 German Hill Road 21222							
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-4-12	9. AGE (In years last birthday) 58	10. Under 1 Yr. Months: Days:	11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker				10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Alexander Siejack Alec				14. MOTHER'S MAIDEN NAME Rose			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 212-12-5931		17. INFORMANT Records: BCH-4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 4/10/71 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Myocardial infarction				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ~ 2 hrs			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) ASCVD (C) Diabetes Mellitus				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ~ 30 yrs ~ 20 yrs			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Complete Heart Block				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5-6-1971 to 5-6-1971 that (I) (we) last saw the deceased alive on 3-17-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Richard K. Maza				23B. DATE SIGNED 5/6/71		23C. PHYSICIAN'S NAME (Type) Richard K. Maza	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-10-1971		24C. NAME of CEMETERY or CREMATORY Holy Rosary		24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 7 1971		25B. NAME of REGISTRAR Robert E. Maza		25C. FUNERAL DIRECTOR Lilly & Zeiler Inc.		25D. ADDRESS 1901-07 Eastern Ave.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO.	
M-265 71 4412				71 4412	
1. NAME OF DECEASED (Type or Print) ALEXANDER McCORMICK		2. DATE AND HOUR OF DEATH 5/2/71 8 p. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1506			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE INC.		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M 6. RACE N 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/16/17		9. AGE (In years last birthday) 53	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OFF.		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steg		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME John McCormick		14. MOTHER'S MAIDEN NAME Jessie Crafton			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. 229-14-0429		17. INFORMANT Mrs. Lena McCormick	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. I CIRRHOSIS OF LIVER AND/OR HEPATITIS ACUTE (ALCOHOLIC?)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Acute renal insufficiency.					
19A. DATE OF OPERATION 7		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 4/20/71 19 to 5/2/71 19 that (we) last saw the deceased alive on 5/2/71 19 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.					
23A. SIGNATURE Philip Antich		23B. DATE SIGNED 5/2/71		23C. PHYSICIAN'S NAME (Type) PHIL-ANTICH	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-6-71		24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Pk.	
25A. DATE REC'D BY HEALTH DEPT. MAY 7 1971		25B. NAME OF REGISTRAR Philip Antich		25C. FUNERAL DIRECTOR Arlington S. Phillips	
25D. LOCATION Baltimore, Maryland		25E. ADDRESS 1727 N. Monroe St.			

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. **71 4413**

BIRTH NO. **25071 4413**

1. NAME OF DECEASED (Type or Print) BERNARD JACKSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour May 4, 1971 1:35 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1602	
9. DATE OF BIRTH 9-19-49		10. AGE (In years last birthday) 21 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Richmond, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME BERNARD CARTER		14. MOTHER'S MAIDEN NAME Unknown	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 224-68-9736	
18. INFORMANT Bernetta Carter		ADDRESS Richmond, Va.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Gunshot wound of neck		CAUSE OF DEATH Gunshot wound of neck	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
22. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Alley	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 900 Block Calhoun Street		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 5-4-71 1:17 A.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Found shot in alley	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-8-71	
24C. NAME OF CEMETERY or CREMATORY Mt. Olivet Cem.		24D. LOCATION (City, town, or county) (State) Richmond, Virginia	
25A. DATE REC'D BY HEALTH DEPT. MAY 7 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR O. F. Howard		DATE SIGNED 5/5/71	

VS 151-REV. 1/1/68

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. [REDACTED]	
W-323 71 4414				71 4414	
BIRTH NO.				71 4414	
1. NAME OF DECEASED (Type or Print) WHEATSTONE, SHELLIE			2. DATE AND HOUR OF DEATH 5-5-71 0400 AM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 2001		
FULL NAME OF HOSPITAL OR INSTITUTION HARBOR VIEW CONV. CTR			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90			E. STREET AND NUMBER 1805 W. LONGINGTON STREET		
5. SEX M	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-13-14	9. AGE (In years last birthday) 57	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOD CARRIER			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) S.C.
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME HARRY		
14. MOTHER'S MAIDEN NAME JOSEPHINE FIELDS			15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. 250-22-4002			17. INFORMANT Chart,		
18. CAUSE OF DEATH E 9681X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Subdural Hematoma ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Cerebral Hemorrhage secondary to trauma.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2/2/71 3/27/71 2/12/71		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). RT. Hemiplegia					
19A. DATE OF OPERATION 3/27/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Subdural Hematoma		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) Street		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 00-00	
21D. TIME OF INJURY (Approx.) 2/2/71		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? assaulted	
22. I certify that (1) (this hospital) attended the deceased from 5/4 19 71 to 5/5 19 71 that (I) (we) last saw the deceased alive on Did not see 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE K. Krulevitz, MD			23B. DATE SIGNED 5/5/71		
23C. PHYSICIAN'S NAME (Type) Dr Kenneth Krulevitz			23D. ADDRESS 115 West Monument St. Baltimore Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/11/71		24C. NAME OF CEMETERY OR CREMATORY MT Calvary C. metry	
24D. LOCATION (City, town, or county) (State) A A County Md		25A. DATE REC'D BY HEALTH DEPT. MAY 7 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR, Adolphus Halstead		25D. ADDRESS 1206 W North Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4415	
S-524 71 4415 BIRTH NO. 1. NAME OF DECEASED (Type or Print) <i>Mabel Singleton</i>		2. DATE AND HOUR OF DEATH <i>5/14/71</i> <i>11:40 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Lutheran Hospital of Maryland</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>md.</i> B. COUNTY <i>1607</i> C. CITY OR TOWN <i>Balto.</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>1423 Poplar Gr. Street</i>			
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>12-10-15</i>	9. AGE (In years last birthday) <i>55 yrs.</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (State or foreign country) <i>Georgetown S.C.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Fred Swider</i>			
14. MOTHER'S MAIDEN NAME <i>Rose Duncan</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			
16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Chae</i> ADDRESS			
18. CAUSE OF DEATH 1B. 43691 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <i>0</i>					
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>2:47 PM 5-4-71</i> to <i>11:40 PM 5-4-71</i>, that (I) (we) last saw the deceased alive on <i>11:40 PM 5-4-71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>O. J. Kim M.D.</i>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <i>OK JA Kim M.D.</i>				23D. ADDRESS <i>730 Ashburton St. Balto, Md.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5-9-71</i>		24C. NAME OF CEMETERY or CREMATORY <i>7, on Church Cr.</i>	
24D. LOCATION (City, town, or county) (State) <i>Georgetown S.C.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>MAY 7 1971</i>			
25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>Henry O. Wilson</i> ADDRESS <i>Balto. Md.</i> <i>Marygalt Funeral Home S.S.</i>			

Life in the
South Sea Islands

Vol. 1

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1. NAME OF DECEASED (Type or Print) Stepson Wilson (Stetson)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 5 Day 2 Year 71 Hour 8:45 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 Bon Secours Hospital		3. DATE PRONOUNCED DEAD Month 5 Day 2 Year 71 Hour 8:45 p.m.	
6. SEX male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH Sept 19-94		10. AGE (In years last birthday) 77	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Taylor O Wilson		14. MOTHER'S MAIDEN NAME Mary Smith	
15. USUAL OCCUPATION (Give kind of work done during most of working life, when if retired) Funeral Director		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT Cliff 5237 Calhoun St	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, MD EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 5/3/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/6-71	
24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cem.		24D. LOCATION (City, town, or county) (State) Md	
25A. DATE REC'D BY HEALTH DEPT. MAY 7 1971		25B. NAME OF REGISTRAR Robert A. Taylor, M.D.	
25C. FUNERAL DIRECTOR Rayner Sanders		25D. ADDRESS 217 E Preston St	

Stylus

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4417	
BIRTH NO. G-653 71 4417				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) GRANT, MR. WILLIAM			2. DATE AND HOUR OF DEATH 4/28/71 5:00 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 BON SECOURS HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1501		
			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 1517 PRESTMAN STREET 21217		
5. SEX M	6. RACE B	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 08-01-04	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER			10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.			13. FATHER'S NAME JAMES GRANT		
14. MOTHER'S MAIDEN NAME EVELYN Lee			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNKNOWN		
16. SOCIAL SECURITY NO. 218-07-0195A			17. INFORMANT CHART		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) —			CAUSE OF DEATH Squamous Cell CA		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. —			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: as per squamous		
			(B) pneumonia DUE TO, OR AS A CONSEQUENCE OF: 2 days		
			(C) —		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 4-22-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA, lower esophagus		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-16-71 19 to 4-28 1971 that (I) (we) last saw the deceased alive on 4-27-71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Francis McBay				23B. DATE SIGNED 4-28-71	
23C. PHYSICIAN'S NAME (Type) NARCISO A. DE BORJA				23D. ADDRESS BON SECOURS HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/1/71		24C. NAME OF CEMETERY OR CREMATORY Arbitus Memorial Park Balto Co. Md	
24D. LOCATION (City, town, or county) (State) BALTIMORE MD		25A. DATE REC'D BY HEALTH DEPT. MAY 7 1971			
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Rayner Sanders 217 E. Preston St.			



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BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 71 4418				MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 71 4418			
1. NAME OF DECEASED (Type or Print) WILLIE LEE ELLIS				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.							
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 110 N. Poppleton Street				3. DATE PRONOUNCED DEAD Month Day Year Hour April 26, 1971 1:15 P.M.							
6. SEX Male		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH 7-15-22		10. AGE (In years lost birthday) 42		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 110 N. Poppleton Street					
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Bennie Wood				15. MOTHER'S MAIDEN NAME Hattie Wood			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		18. INFORMANT Mary Gabsoden-1045 Hanover-St.				ADDRESS			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes		17. SOCIAL SECURITY NO. 259-24-2829		19. CAUSE OF DEATH Cancer of Lung				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
MEDICAL CERTIFICATION DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:							
				(B) DUE TO, OR AS A CONSEQUENCE OF:							
				(C) DUE TO, OR AS A CONSEQUENCE OF:							
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) no					
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?							
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?							
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/27/71											
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-1-71		24C. NAME of CEMETERY or CREMATORY Mount Calvary		24D. LOCATION (City, town, or county) (State) A.A/Co., Md					
25A. DATE REC'D BY HEALTH DEPT. MAY 7 1971		25B. NAME OF REGISTRAR <i>Robert E. Taylor, Jr.</i>		25C. FUNERAL DIRECTOR Isaiah L. Brown & Son		ADDRESS 108 W. Montgomery Street					

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 71 4419

BIRTH NO. 71 4419		2. DATE AND HOUR OF DEATH May 6, 1971 1:00 A.M.	
1. NAME OF DECEASED (Type or Print) Cary Dorsey Hall, Jr.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. 8. COUNTY 909	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Long Green Nursing Home		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX male 6. RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/9/1880 9. AGE (in years last birthday) 91	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Attorney		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
10B. KIND OF BUSINESS OR INDUSTRY Law		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Cary Dorsey Hall, Sr.		14. MOTHER'S MAIDEN NAME Elizabeth S. Gill	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 220-99-6057A	
17. INFORMANT Mrs. Ralph A. Leaf		ADDRESS 1425 Continental Lane Beaumont, Texas	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.		IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Fracture of Left Hip	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY Yes or No No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Nursing Home	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Baltimore City - 115 E. Mohr Ave 21212			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) May 2 1971 11:00 AM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	
21F. HOW DID INJURY OCCUR? Fell inside his bed			
22. I certify that (I) (this hospital) attended the deceased from May 8-8 1971 to May 6 1971 and that (I) (we) last saw the deceased alive on May 5 1971 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE OF PHYSICIAN Dr. William G. Helfrich M. D.		23B. DATE SIGNED 6 May 71	
23C. PHYSICIAN'S NAME (Type) Dr. William G. Helfrich M. D.		23D. ADDRESS 5006 Roland Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/8/71	
24C. NAME OF CEMETERY OR CREMATORY Greenmount		24D. LOCATION Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 7 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR H.W. Jenkins Sons Co.		ADDRESS 4905 York Rd. Baltimore, Maryland 21212	



Approved & Released by MB on 5/6/71
FUNERAL DIRECTOR: IMPORTANT
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

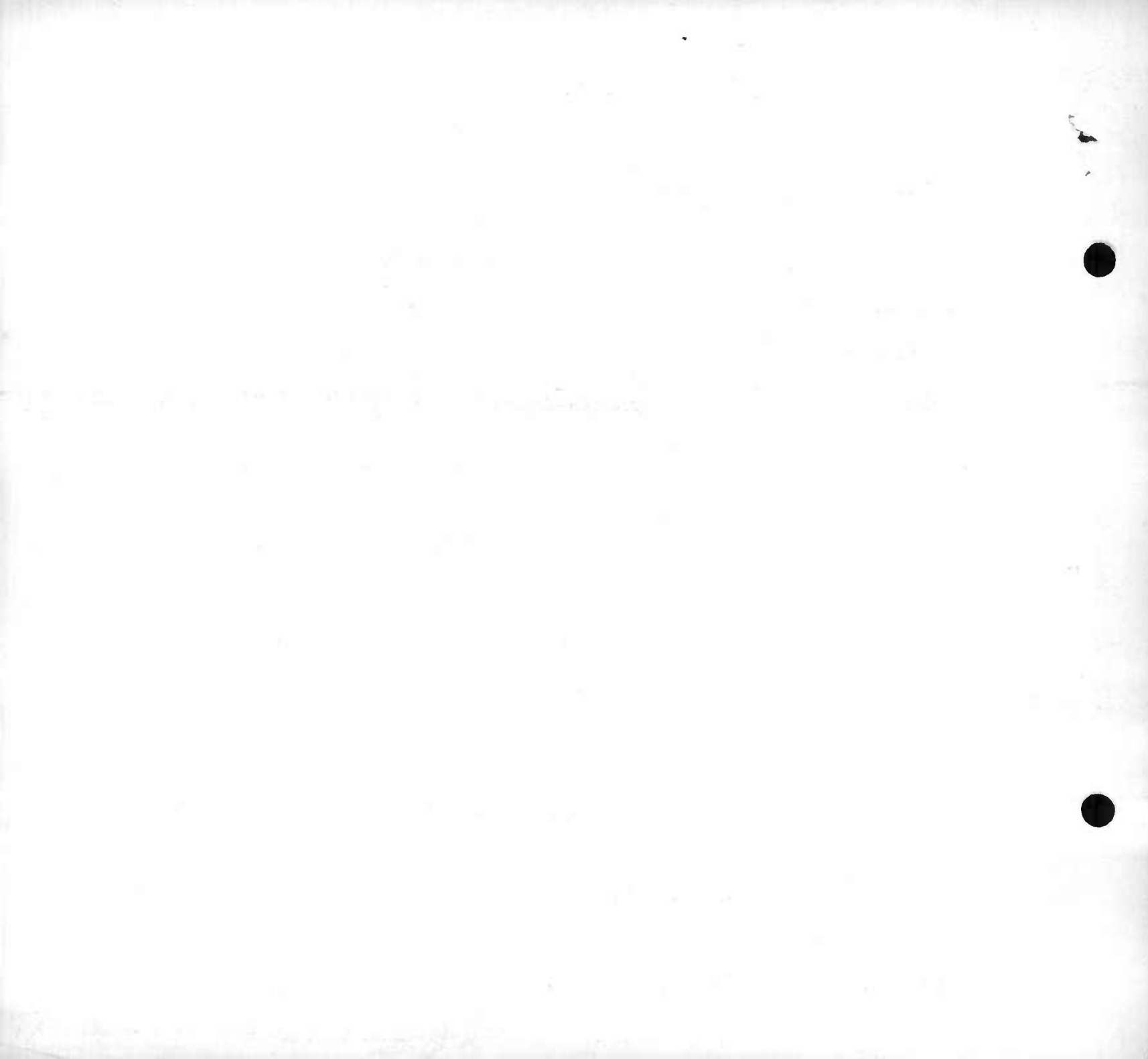
BALTIMORE CITY HEALTH DEPARTMENT				71-4420	
CERTIFICATE OF DEATH				REG. NO. 71-4420	
BIRTH NO. 71 4420					
1. NAME OF DECEASED (Type or Print) CHARLES R. SEAL		2. DATE AND HOUR OF DEATH May 6, 1971 12:25 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 44 Union Memorial Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY Baltimore Maryland 2714			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hospital		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 6-29-90		9. AGE (In years last birthday) 80		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LAWYER		10B. KIND OF BUSINESS OR INDUSTRY LAW		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME Thomas Seal		14. MOTHER'S MAIDEN NAME Emma Sull	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W.I.		16. SOCIAL SECURITY NO. R13-03-8358A		17. INFORMANT MRS. JESSIE D. SEAL (SAME)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from April 27 1971 to May 6 1971, that (I) (we) last saw the deceased alive on May 6 1971, and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE 23B. DATE SIGNED 23C. PHYSICIAN'S NAME (Type) 23D. ADDRESS 24A. BURIAL CREMATION, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETERY OR CREMATORY 24D. LOCATION (City, town, or county) (State) 25A. DATE REC'D BY HEALTH DEPT. 25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR ADDRESS					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 4421	
BIRTH NO. 71 4421		1. NAME OF DECEASED (Type or Print) Gail A. Osborne		2. DATE AND HOUR OF DEATH 5/4/71 1248 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD University Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 2706			
FULL NAME OF HOSPITAL OR INSTITUTION University Hospital		C. CITY OR TOWN Balto.		D. INSIDE CITY (LIMITS)? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F. 6. RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-28-1949 9. AGE (In years last birthday) 22	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rental Ass't.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME Frank Osborne		14. MOTHER'S MAIDEN NAME Mary White			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-50-6540		17. INFORMANT Mrs. Mary Osborne ADDRESS 1006 S. Boulding	
18. E-750-1		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		pulmonary edema 3 weeks	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, -giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) drug overdose DUE TO, OR AS A CONSEQUENCE OF:		3 weeks	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		neurosis of trachea		1 week	
19A. DATE OF OPERATION 5/2/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED tracheal neurosis		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2211 Westfield Ave 2706	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 4/9/71		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? took overdose of unknown drug	
22. I certify that (I) (this hospital) attended the deceased from 4/23 19 71 to 5/4 19 71 that (I) (we) last saw the deceased alive on 5/4 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE David W. Fricke MD				23B. DATE SIGNED 5/4/71	
23C. PHYSICIAN'S NAME (Type) David W. Fricke MD		23D. ADDRESS Hoffmann Funeral Home - 3218 Hudson			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-7-71		24C. NAME OF CEMETERY or CREMATORY Oak Lawn	
24D. LOCATION Balto.		24E. STATE Md.		24F. CITY OR TOWN Balto.	
25A. DATE REC'D BY HEALTH DEPT. MAY 7 1971		25B. NAME OF REGISTRAR Robert E. Farber, R.D.		25C. FUNERAL DIRECTOR Hoffmann Funeral Home	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 4422</u>	
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Miller, Alfred L.		May <u>4</u> , 1971 2:00 p. m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>39</u> Provident Hospital, Inc. 2600 Liberty Heights Avenue Baltimore, Maryland 21215			A. STATE Maryland C. CITY OR TOWN Baltimore, D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1307 Fremont Avenue		
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-15-1920	9. AGE (In years last birthday) 51	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed			11. BIRTHPLACE (State or foreign country) Deep Creek, Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Leroy Miller			14. MOTHER'S MAIDEN NAME Lillie Lloyd		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 238-16-5660	17. INFORMANT Eddie Miller Brother 1700 Madison Avenue		
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF: (B) Pneumonia of the lungs with metastases DUE TO, OR AS A CONSEQUENCE OF: (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4-21-71</u> to <u>5-4-71</u> and that (I) (we) last saw the deceased alive on <u>5-4-71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Sabode</i>			23B. DATE SIGNED 5-5-71		
23C. PHYSICIAN'S NAME (Type) DR. JUANITO C. TABADA			23D. ADDRESS PROVIDENT HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		5-10-71		Mt. Auburn	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAY 7 1971		Robert E. Taylor, R.D.		Mary-Elizabeth Law 802 Madison Ave.	

1000 Liberty Bell
Baltimore, Maryland 21210

1000 Liberty Bell

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>4423</u>	
CERTIFICATE OF DEATH					
BIRTH NO. <u>71 4423</u>					
1. NAME OF DECEASED (Type or Print) <u>JOSEPH B. LENTZ</u>		2. DATE AND HOUR OF DEATH <u>MAY 5, 1971</u>		<u>630 PM.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 Union Memorial Hosp.</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3931 Ednor Road</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/11/24</u>	9. AGE (In years last birthday) <u>46</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES CLERK</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Wholesale Tobacco/Candy</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Felix W. Lentz</u>		14. MOTHER'S MAIDEN NAME <u>Helen Wojtkiewicz</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes <u>WW II</u>		16. SOCIAL SECURITY NO. <u>216-16-2122</u>		17. INFORMANT ADDRESS <u>Mrs. Helen Lentz, 3931 Ednor Road</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute myocardial infarction</u> SECONDARY TO (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>severe coronary atherosclerosis</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Rostram Algalin</u> (C) <u>Rostram Algalin</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>5-10-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>MAY 4</u> 19 <u>71</u> to <u>MAY 5</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>MAY 5</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>David J. Powner, MD</u>				23B. DATE SIGNED <u>MAY 6, 1971</u>	
23C. PHYSICIAN'S NAME (Type) <u>DAVID J. Powner MD</u>				23D. ADDRESS <u>Union Memorial Hosp</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/8/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 7 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Sadowski, R.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>M.F. SADOWSKI & SONS, 1808 EASTERN AVE.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

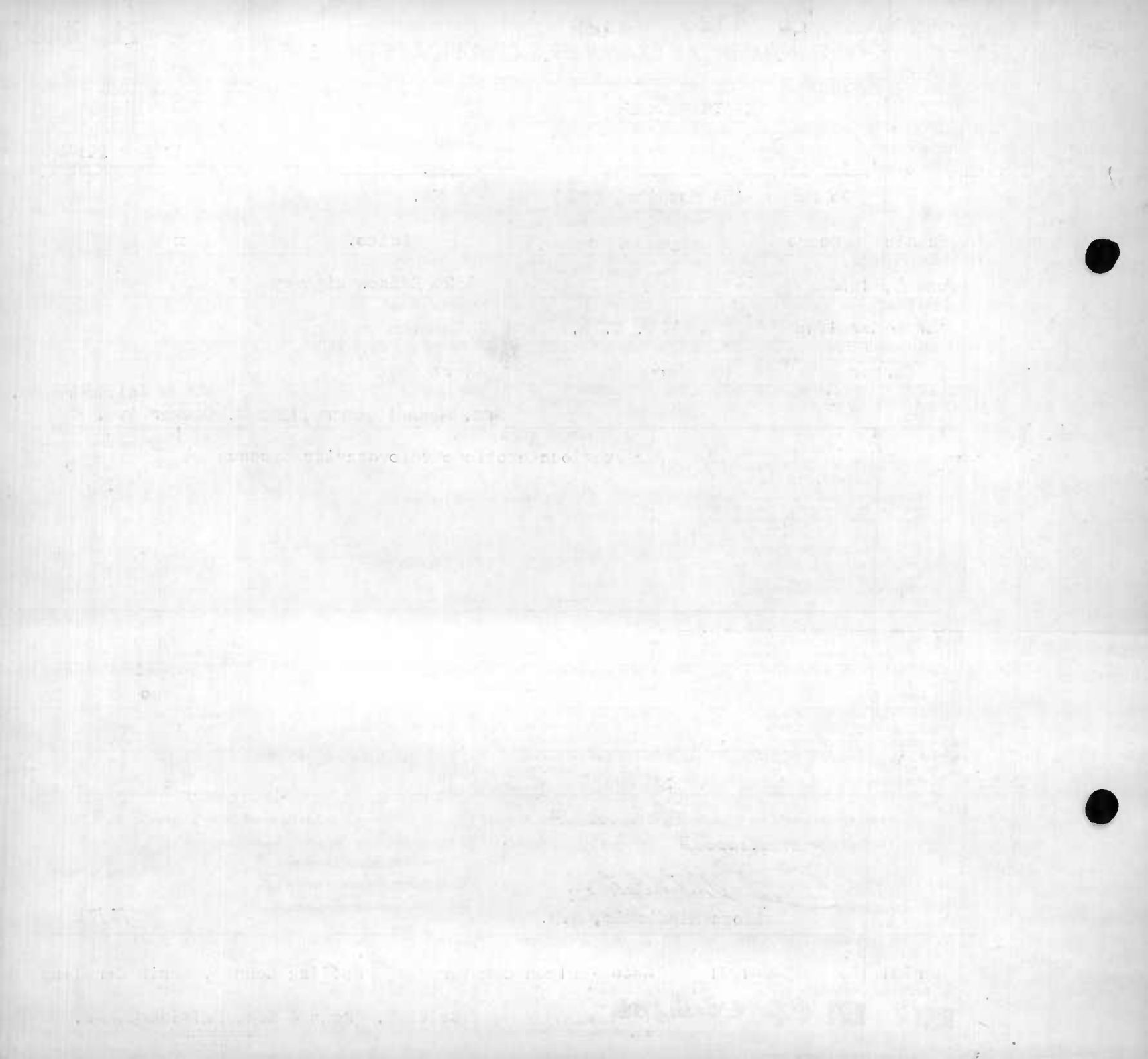
BALTIMORE CITY HEALTH DEPARTMENT				X REG. NO. <u>71 4424</u>	
BIRTH NO. <u>N-218</u>		71 4424		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>George T. Neighoff</u>			2. DATE AND HOUR OF DEATH <u>5-4-71</u> <u>110:40 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>42 Sinai Hospital</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Reisterstown</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>116 Delight Rd # 21136</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-16-94</u>	9. AGE (in years lost birthday) <u>76</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Asphalt Paving</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Charles E. Neighoff</u>		
14. MOTHER'S MAIDEN NAME <u>Isabelle Dibbs</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>W.W.I</u>		
16. SOCIAL SECURITY NO. <u>579-01-9304</u>			17. INFORMANT <u>Thelma Neighoff, 116 Delight Rd. Reisterstown, Md.</u>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>pneumonia</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>April 12</u> , 19 <u>71</u> to <u>May 4</u> , 19 <u>71</u> and that (I) (we) last saw the deceased alive on <u>May 4</u> , 19 <u>71</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Marcia Waterbury, M.D.</u>				23B. DATE SIGNED <u>5-4-71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Marcia Waterbury</u>				23D. ADDRESS <u>Sinai Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>May 7, 1971</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Lake View Mem Park</u>	
24D. LOCATION (City, town, or county) (State) <u>Sykesville, Carroll, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 7 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Jones</u>		25C. FUNERAL DIRECTOR <u>H. J. Sillhardt, Owings Mills, Md.</u>			

✓

Continued
Gravel & Asphalt Paving
Yes W.C.I. 2-2-54
Gravel & Asphalt, no Ditch
Ipswich, D.D.P.
Maryland

W.C.I. 2-2-54
Ipswich, D.D.P.
Gravel & Asphalt, no Ditch
Ipswich, D.D.P.
Maryland

BALTIMORE CITY HEALTH DEPARTMENT				71 4425			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH							
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE OF DEATH			
NELLIE FALCON				Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				3. DATE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				Month Day Year Hour			
Johns Hopkins Hospital (DQA)				5 2 1971 11:13 P.			
6. SEX				5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
female				A. STATE B. COUNTY			
7. RACE				C. CITY OR TOWN D. INSIDE CITY LIMITS?			
negro				Balto. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				E. STREET AND NUMBER			
9. DATE OF BIRTH				1526 Edison Highway			
June 9, 1896				10. AGE (In years lost birthday) 74			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
North Carolina				U. S. A.			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				15. MOTHER'S MAIDEN NAME			
Farmer				Flora Boyd			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				17. SOCIAL SECURITY NO.			
No				18. INFORMANT ADDRESS Baltimore, Md.			
19. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				Arteriosclerotic cardiovascular disease			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
20A. DATE OF OPERATION				21. AUTOPSY? (Yes or No)			
20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?							
22D. TIME OF INJURY (APPROX.)				22E. INJURY OCCURRED			
(Month) (Day) (Year) (Hour)				WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22F. HOW DID INJURY OCCUR?							
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Isidore Mihalakis, M.D.				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED				5/3/71			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE			
Burial				5-8-1971			
24C. NAME of CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
Fate Falcon Cemetery				Halifax County, North Carolina			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
MAY 7 1971				Robert E. Fahey, M.D.			
25C. FUNERAL DIRECTOR				ADDRESS			
Isaiah L. Brown & Son, Baltimore, Md.							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 4426
BIRTH NO. <u>B-650</u> <u>71</u> <u>4426</u>		DATE AND HOUR OF DEATH <u>5-4-71</u> <u>10:05 A M.</u>		
1. NAME OF DECEASED (Type or Print) <u>DONNA KAY BROWN</u>		2. DATE AND HOUR OF DEATH		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>FREDERICK</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>EMMITSBURG</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
		E. STREET AND NUMBER <u>RT 1</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-17-69</u>	9. AGE (In years lost birthday) <u>1</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Baltimore,</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>WILBUR BROWN</u>		14. MOTHER'S MAIDEN NAME <u>FANNIE ROWE</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Mrs. Fannie Brown, Emmitsburg, Md. R.D# 1</u>	
18. <u>74631</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Cardiopulmonary arrest</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiopulmonary arrest</u>		
		(B) <u>Coronary heart disease</u> DUE TO, OR AS A CONSEQUENCE OF:		
		(C)		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>24-27-71</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>PDA, USD</u>	20A. AUTOPSY? (Yes or No) <u>Yes</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>5:33</u>	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that <u>He</u> (this hospital) attended the deceased from <u>3/23</u> 19 <u>71</u> to <u>5-4</u> 19 <u>71</u> that <u>we</u> lost saw the deceased alive on <u>5/4</u> 19 <u>71</u> and that in <u>our</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>We</u> (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>5-4-71</u>		
23C. PHYSICIAN'S NAME (Type) <u>Mr. Jones, M.D.</u>		23D. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>May 6, 1971</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Emmitsburg, Frederick Co. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 7 1971</u>	25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	25C. FUNERAL DIRECTOR <u>Charles E. Wilson</u>		
		ADDRESS <u>Emmitsburg, Md.</u>		

UNITED STATES DEPARTMENT OF AGRICULTURE

REPORT

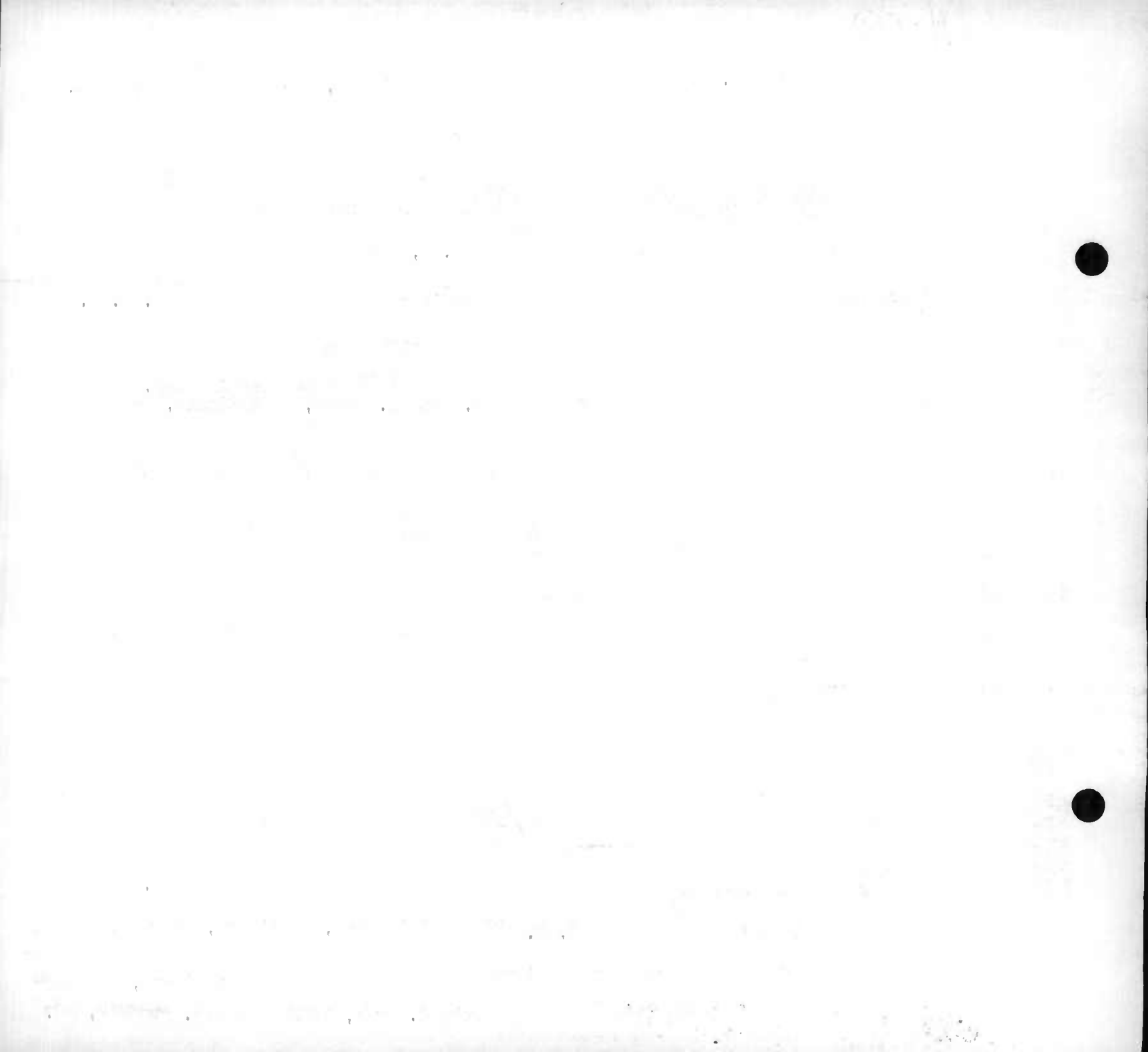
EXHIBIT

M. JONES, R.O.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<h2 style="margin: 0;">N-550 71 4427</h2>		<h3 style="margin: 0;">BALTIMORE CITY HEALTH DEPARTMENT</h3>		<h3 style="margin: 0;">CERTIFICATE OF DEATH</h3>		REG. NO. <u>71 4427</u>	
BIRTH NO. <u>71 4427</u>		1. NAME OF DECEASED (Type or Print) <u>Ethel E. Nunan</u>		2. DATE AND HOUR OF DEATH <u>May 4, 1971</u> <u>1:25</u> P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>70 Gould Convalesarium</u> <u>6116 Belair Road</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2646</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1404 Broening Highway</u>			
5. SEX <u>Female</u>		6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 1, 1896</u>	
9. AGE (In years last birthday) <u>74</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Asa Tubbs</u>				14. MOTHER'S MAIDEN NAME <u>Mary Hanks</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT (Son) <u>1404 Broening Hwy.</u> <u>Mr. Paul A. Nunan, Baltimore, Maryland</u>	
MEDICAL CERTIFICATION 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Acute Coronal Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> <u>upon</u>	
		19A. DATE OF OPERATION _____ 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____					
		20A. AUTOPSY? (Yes or No) <u>No</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____			
22. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>3/11/1971</u> to <u>5/4/1971</u> that (I) (<u>we</u>) last saw the deceased alive on <u>5/3/1971</u> and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>we</u>) (<u>did</u>) (<u>did not</u>) view the body after death.							
23A. SIGNATURE <u>Albert B. Bradley</u>				23B. DATE SIGNED <u>May 5, 1971</u>			
23C. PHYSICIAN'S NAME (Type) <u>Albert Bradley</u>				23D. ADDRESS <u>M. D. 4900 Belair Road, Baltimore, Maryland 21206</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/7/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 7 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Tubbs, M.D.</u>		25C. FUNERAL DIRECTOR <u>John J. Duda, 7922 Wise Ave. Dundalk, Md.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
D-620		71 4428		71 4428	
1. NAME OF DECEASED Type or Print			2. DATE AND HOUR OF DEATH		
GEORGE DEAKES			5/6/71 5:10 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION			A. STATE		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			B. COUNTY		
21224			MD		
3/BALTIMORE CITY HOSPITALS			C. CITY OR TOWN		
4940 Eastern Avenue, Baltimore, Maryland			BALTIMORE		
			D. INSIDE CITY LIMITS?		
			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER		
			925 S STREEPER ST. 21224		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. CITIZEN OF WHAT COUNTRY
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	5/25/95	75	UNITED STATES
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
RETIRED				MD	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
JACOB			ROSE		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
No			218-10-1095		
			17. INFORMANT		
			ADDRESS		
			Records: BCH-4940 Eastern Avenue 21224		
18. CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 8/22 1970 to 5/6 1971 that (I) (we) last saw the deceased alive on 5/6/71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Jorge R. Ayon				5/6/71	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
JORGE R. AYON M.D.				4940 Eastern Avenue, Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		5-8-71		Oak Lawn	
				24D. LOCATION (City, town, or county) (State)	
				Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
7/1/71		Robert E. Taylor, R.R.		Helene A. Hoffmann	
				ADDRESS	
				3218 Hudson St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 4429	
BIRTH NO. J-520 71 4429		1. NAME OF DECEASED (Type or Print) CHARLES S. JONES		2. DATE AND HOUR OF DEATH 6 MAY 1971 4:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4 SINAI HOSPITAL.		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY 2755 C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2017 KELLY AVE.			
5. SEX M	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 JUL 1900	9. AGE (In years last birthday) 70	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY LANDSCAPE GARDNER		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME REV. THOMAS M. JONES		14. MOTHER'S MAIDEN NAME MARY ELLEN HALL	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212 32 2664		17. INFORMANT ADDRESS CHARLES W JONES 2017 KELLY AVENUE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 412.214.250.9 CEREBRAL HEMORRHAGE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD HYPERTENSION DIABETES MELLITUS		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HOURS YEARS YEARS YEARS	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19A. DATE OF OPERATION 10		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (He/this hospital) attended the deceased from 5 May 1971 to 6 May 1971 that (He/we) last saw the deceased alive on 5 May 1971 and that (my/our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Arthur M. Wagner, M.D.				23B. DATE SIGNED 6 MAY 1971	
23C. PHYSICIAN'S NAME (Type) ARTHUR M. WAGNER M.D.				23D. ADDRESS SINAI HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 5/10/71		24C. NAME OF CEMETERY OR CREMATORY CARVER MEMORIAL PARK	
24D. LOCATION (City, town, or county) LAUREL, MARYLAND		24E. DATE REGISTRY HEARD 7 MAY 1971		24F. NAME OF REGISTRAR Robert E. Taylor, Jr.	
25. FUNERAL DIRECTOR ADDRESS LEWIS T GWYNN 4517 PARK HEIGHTS AVE.					

1991-1992

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1991-1992

G-600

71 4430

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 4430

BIRTH NO.

1. NAME OF DECEASED (Type or Print) KEVIN GRAY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 SINAI HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour April 29, 1971 10:55 AM	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2717	
9. DATE OF BIRTH April 24, 61		10. AGE (In years lost birthday) 10 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Gray		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed	
15. MOTHER'S MAIDEN NAME Delores Baker		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO. NONE		18. INFORMANT Delores Gray 4900 Palmer Avenue	
19. 37371 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral Palsy DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no		22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Werner U. Spitz M.D.		DATE SIGNED 4/30/71	
EXAMINER'S NAME (Type) Werner U. Spitz M.D.		DEPUTY CHIEF MEDICAL EXAMINER Deputy Chief Medical Examiner	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/3/71	
24C. NAME OF CEMETERY or CREMATORY Putty Hill Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore (Balto.) Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 7 1971		25B. NAME OF REGISTRAR Delores E. Baker, M.D.	
25C. FUNERAL DIRECTOR LEWIS T GWYNN		ADDRESS 4517 Park Heights Ave.	

WITNESS FOR

EXHIBIT

100

100

100

100

100

100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. <u>71 4431</u>	
D-242 71 4431		71 4431		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Mary C. KATHERINE DOUGLAS</u>		2. DATE AND HOUR OF DEATH <u>5-5-71</u> <u>1:40</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>33 THE JOHNS HOPKINS HOSPITAL</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>1324 N. DALLAS ST.</u>	
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-9-30</u>	9. AGE (In years last birthday) <u>40</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>N. Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>HENRY DOUGLAS</u>		14. MOTHER'S MAIDEN NAME <u>FANNIE PERRY</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Fromie Bydune-1202 1/2nd St.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>303.21</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Metabolic Imbalance</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Alcoholic Cardiomyopathy</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Organic Brain Syndrome</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>3 wks</u> <u>3 wks</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Superinfected Sacral Decubitis</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/16</u> 19 <u>71</u> to <u>5/5</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>5/5</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>S.J. Elfenbein MD</u>		23B. DATE SIGNED <u>5/5/71</u>		23C. PHYSICIAN'S NAME (Type) <u>G.J. ELFENBEIN, M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-8-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Liberty Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>A. A. County, Md.</u>		25A. DATE OF DEATH <u>MAY 10 1971</u>		25B. NAME OF REGISTRAR <u>CELESTINE N. 1129 N. Carroll</u>	
25C. FUNERAL DIRECTOR <u>CELESTINE N. 1129 N. Carroll</u>					

7. 34200

Y 437 11/20/40

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

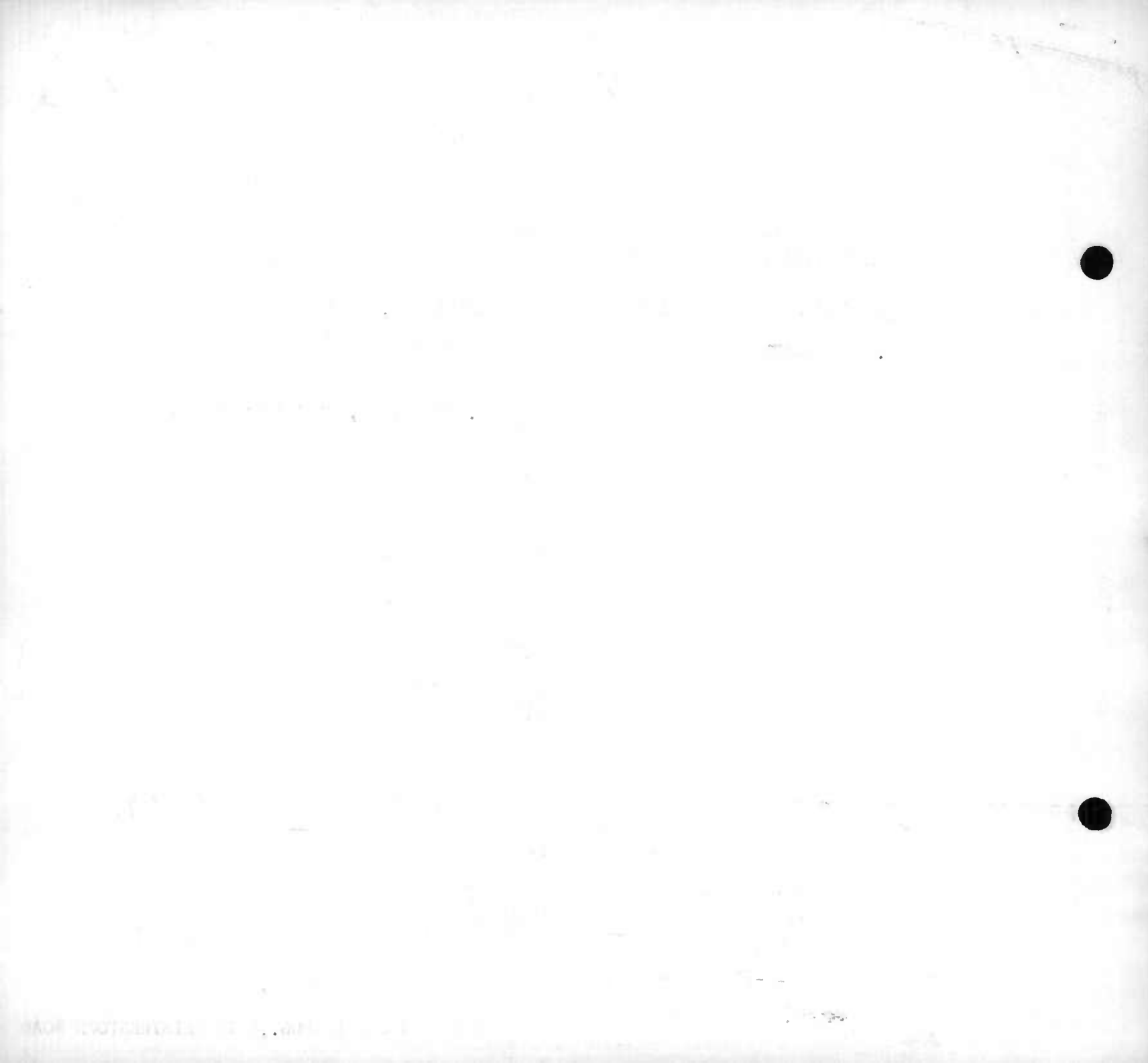
BALTIMORE CITY HEALTH DEPARTMENT									
S-165 71 4432					REG. NO. 71 4432				
BIRTH NO.					CERTIFICATE OF DEATH				
1. NAME OF DECEASED (Type or Print) SHEFFERMAN, JULES					2. DATE AND HOUR OF DEATH 5-5-71 11:10 PM				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL					A. STATE MARYLAND				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					B. COUNTY Baltimore				
C. CITY OR TOWN BALTIMORE					D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>				
E. STREET AND NUMBER 3516 RHOM RD					5300				
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/XX/01	9. AGE (in years last birthday) 69	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Min.	12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME BENJAMIN SHEFFERMAN	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ATTORNEY		10B. KIND OF BUSINESS OR INDUSTRY AT LAW		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO					16. SOCIAL SECURITY NO. 217-38-7536		17. INFORMANT MRS. HELEN SHEFFERMAN, 2518 RHOM ROAD XXXX		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH PULMONARY EMBOLISM (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HR				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). HYPERTENSIVE CARDIOVASCULAR DISEASE SEVERE EMPHYSEMA				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 5-2-1971 to 5-5-1971 that (I) (we) last saw the deceased alive on 5-5-71 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Ferdinand A. Martinez MD					23B. DATE SIGNED 5-5-71			23C. PHYSICIAN'S NAME (Type) FERDINANDO A. MARTINEZ MD	
23D. ADDRESS SINAI HOSPITAL									
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 5-7-71		24C. NAME of CEMETERY or CREMATORY MIKRO KODESH-BETH ISRAEL		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND			
25A. DATE, REC'D BY HEALTH DEPT. MAY 10 1971		25B. NAME OF REGISTRAR John E. Fisher MD		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS.		25D. ADDRESS 6010 REISTERSTOWN ROAD			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

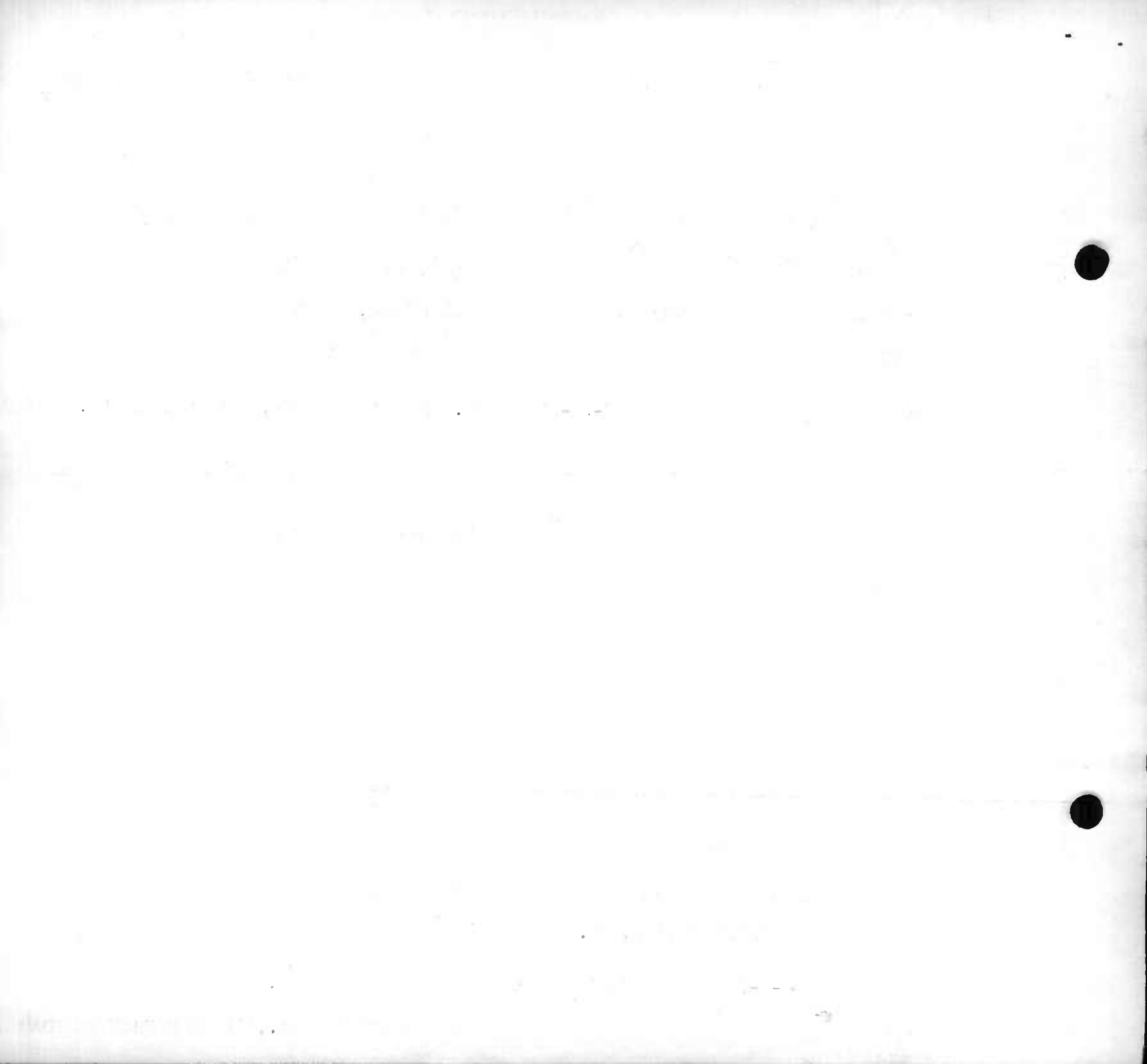
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 4433</u>	
L-000 71 4433				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>EVELYN LOEW</u>		2. DATE AND HOUR OF DEATH <u>5/5/71</u> <u>6.15</u> <u>a.m.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTO.</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL OF BALTIMORE INC.</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u>		6. RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>4/8/17</u>		9. AGE (In years last birthday) <u>54</u>		If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>I. RAL GLASER</u>		14. MOTHER'S MAIDEN NAME <u>BESSIE SCHLOSSBERG</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>MR. PAUL LOEW, 2711 GLEN AVENUE #21215</u>	
18. <u>4707 I</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Acute Myocardial Infarction</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <u>4/27/71</u> 19 to <u>5/5/71</u> 19 that (we) last saw the deceased alive on <u>5/5/71</u> 19 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.					
23A. SIGNATURE <u>Dr. Paul Antich</u>				23B. DATE SIGNED <u>5/5/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>PAUL ANTICH</u>				23D. ADDRESS <u>SINAI HOSPITAL BALTO 21215</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>5-6-71</u>		24C. NAME of CEMETERY or CREMATORY <u>BETH TFILOH</u>	
24D. LOCATION (City, town, or county) (State)		<u>BALTIMORE, MARYLAND</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1971</u>		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 4434		REG. NO. 71 4434	
BIRTH NO. 0-600		71 4434		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>IRVIN BAER</u>				2. DATE AND HOUR OF DEATH <u>5/3/71</u> <u>8:05 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL OF BALTO BELVEDERE & GREENSPRING</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>MD</u>		B. COUNTY	
5. SEX <u>MALE</u>		6. RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/1/97</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>MERCHANT</u>		9. AGE (In years lost birthday) <u>73</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>	
13. FATHER'S NAME <u>GUSTAV BAER</u>				14. MOTHER'S MAIDEN NAME <u>ANNA ?</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-32-3766</u>		17. INFORMANT ADDRESS <u>MRS. ALMA LOUISE BAER, 2311 KEN OAK RD. #21209</u>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Cerebrovascular Accident</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Cerebroarterio sclerosis</u> (B) _____ (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 yrs</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>none</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>5/3</u> 19 <u>71</u> to <u>5/3</u> 19 <u>71</u> and that (I) (we) last saw the deceased alive on <u>5/3</u> 19 <u>71</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Maurice Feldman</u>				23B. DATE SIGNED <u>5/3/71</u>		23C. PHYSICIAN'S NAME (Type) <u>MAURICE FELDMAN, JR.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>5-6-71</u>		24C. NAME of CEMETERY or CREMATORY <u>BALTIMORE HEBREW</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1971</u>		25B. NAME OF REGISTRAR <u>Sub E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 4435</u>	
BIRTH NO. <u>D-255</u> <u>71 4435</u>		1. NAME OF DECEASED (Type or Print) <u>CLYDE L. DISHMAN, SR.</u>		2. DATE AND HOUR OF DEATH <u>May 6, 1971</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>454 S. Furrow Street</u> <u>Baltimore, Maryland 21223</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>454 S. Furrow Street</u>		
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-30-1914</u> <u>1915</u> <u>56</u> <u>55</u>	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mechanic</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Sewing Machine Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
13. FATHER'S NAME <u>Robert Dishman</u>			14. MOTHER'S MAIDEN NAME <u>Rosa Scott</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>W W II</u>			16. SOCIAL SECURITY NO. <u>224-07-1806</u>		17. INFORMANT <u>Mrs. Verna Dishman, 454 S. Furrow St. 21223</u>
18. <u>162.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>metastatic disease (terminal stage)</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Carcinoma of the lungs,</u> <u>Carcinoma of the urinary bladder</u> <u>Carcinoma of the neck</u> <u>Omphalocele</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>weeks</u> <u>weeks</u> <u>years</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>5/3/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4.4.1969</u> to <u>5/6/71</u> that (I) (we) last saw the deceased alive on <u>5/3/71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Henry Armanas</u>				23B. DATE SIGNED <u>5.7.71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Henry Armanas</u>				23D. ADDRESS <u>1934 Wilkens Avenue, Baltimore, Md. 21223</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-10-1971</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
CERTIFICATE OF DEATH											
REG. NO. 71 4436											
BIRTH NO. 1. NAME OF DECEASED (Type or Print)		ELMER HAGNER - Sr.				2. DATE AND HOUR OF DEATH %X 5-5-71 M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)						
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					A. STATE B. COUNTY C. CITY OR TOWN D. INSIDE CITY LIMITS?						
33 THE JOHNS HOPKINS HOSPITAL					MARYLAND A. A. CO ORCHARD BEACH PASADENA YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
5. SEX MALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 8-21-08 92		9. AGE (In years last birthday) 78		10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Supervisor					10B. KIND OF BUSINESS OR INDUSTRY Maint @ Hosp					11. BIRTHPLACE (State or foreign country) Ind	
12. CITIZEN OF WHAT COUNTRY USA					13. FATHER'S NAME ADAM HAGNER					14. MOTHER'S MAIDEN NAME CARRIE WELSH	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 215-07-7790		17. INFORMANT Elmer J. Hagner Jr. R. S. Burdette				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)											
CAUSE OF DEATH Metastatic Carcinoma site unknown											
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION 4/30		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Laparotomy for dx		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (1) (this hospital) attended the deceased from 5/1 19 71 to 5/5 19 71 that (1) (we) last saw the deceased alive on 5/5 19 71 and that in my (aur) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Richard L. Taw Jr MD					23B. DATE SIGNED 5/5/71		23C. PHYSICIAN'S NAME (Type) RICHARD L. TAW JR., MD				
23D. ADDRESS THE JOHNS HOPKINS HOSPITAL											
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE 5/8/71		24C. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem		24D. LOCATION (City, town, or county) Baltimore		(State) Md.			
25A. DATE REC'D BY HEALTH DEPT. MAY 10 1971		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Robert S. Burdette		ADDRESS					

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-620 71 4437		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 4437	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) PRICE, Rhoda ANN			
2. DATE AND HOUR OF DEATH 9-5-71 6:20 AM				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital				IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Baltimore				C. CITY OR TOWN Baltimore			
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				E. STREET AND NUMBER 1227 Primrose Ave 5380			
5. SEX F		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-21-37	
9. AGE (In years last birthday) 33		10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10B. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME DOYLEE PRUNTY SR.				14. MOTHER'S MAIDEN NAME AUDREY DAWSON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO.		17. INFORMANT John G. Price, 1227 Primrose Ave. 21237	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 747.1 CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac arrest. (B) POOR CARDIO-PULMONARY DYNAMICS. (C) COARCTATION OF AORTA. DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Hypertension.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 5-5-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Severe coarctation of aorta		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5-1-71 19 to 5-5-71 19 71 that (I) (we) last saw the deceased alive on 5-2-71 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Bryan M.D.				23B. DATE SIGNED 5-5-71		23C. PHYSICIAN'S NAME (Type) BRYAN M.D.	
23D. ADDRESS THE JOHNS HOPKINS HOSPITAL				23E. FUNERAL DIRECTOR Ullrich Funeral Homes, Dundalk, Md. 21222			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 10 May 71		24C. NAME of CEMETERY or CREMATORY Holly Hill Memorial Gardens		24D. LOCATION (City, town, or county) (State) Baltimore County, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 10 1971		25B. NAME OF REGISTRAR Robert E. Gable, M.D.		25C. FUNERAL DIRECTOR Ullrich Funeral Homes, Dundalk, Md. 21222			

YU. I. VODNIN

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>71 4438</u>	
L-536 <u>71 4438</u>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>LOUIS FRANK LINDER</u>		2. DATE AND HOUR OF DEATH <u>5/4/71</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>40 ST. AGNES HOSP.</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTO.</u> C. CITY OR TOWN <u>ARBUTUS</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>5105 SHELBOURNE RD 21227</u>	
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/3/1900</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AUTO MECH.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AUTO</u>	9. AGE (in years last birthday) <u>70</u>
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>LOUIS F. LINDER</u>		14. MOTHER'S MAIDEN NAME <u>MAGGIE SEIDEL</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218220312</u>	
17. INFORMANT <u>LOUIS R. LINDER</u>		ADDRESS	
18. <u>4/10/71</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <u>4/10/71</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute M.I.</u> (B) <u>Coronary atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: (C)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (i) (this hospital) attended the deceased from <u>4/6</u> 19 <u>64</u> to <u>5/4</u> 19 <u>71</u> that (i) (we) last saw the deceased alive on <u>4/20</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (i) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>5/5/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>[Signature]</u>		23D. ADDRESS <u>[Signature]</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>5/8/71</u>	
24C. NAME of CEMETERY or CREMATORY <u>MEADOWRIDGE</u>		24D. LOCATION (City, town, or county) (State) <u>HOWARD CO. MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
25C. FUNERAL DIRECTOR <u>MACNABB & SON</u>		ADDRESS <u>21228</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		71 4439	
N-000 71 4439		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>NEV Alice Theresa</i>		2. DATE AND HOUR OF DEATH <i>5/7/71 2:45 A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <i>North Charles Gen Hosp</i>		A. STATE <i>MD.</i>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>49 2724 N. Charles ST</i>		B. COUNTY <i>Baltimore</i>	
5. SEX <i>F</i>		6. RACE <i>W</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>3/7/14</i>	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <i>57</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>H. W.</i>		11. BIRTHPLACE (State or foreign country) <i>PENNA</i>	
10B. KIND OF BUSINESS OR INDUSTRY <i>-</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Ladden (D)</i>		14. MOTHER'S MAIDEN NAME <i>ELIZABETH FARRELL (D)</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>T78-012366</i>	
17. INFORMANT <i>LORD Funeral Salm, Hosp. chart Pottsville Penna</i>		ADDRESS <i>-</i>	
18. CAUSE OF DEATH <i>412.3 I</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>ASCVD, CHF</i>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>CAD, ASCVD</i>		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) _____		(C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <i>5-4</i> 19 <i>71</i> to <i>5-7</i> 19 <i>71</i> that (1) (we) last saw the deceased alive on <i>5-7</i> 19 <i>71</i> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Benjamin Highstein</i>		23B. DATE SIGNED <i>5-7-71</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <i>121 S. HIGHLAND AVE BALTO. Md 21204</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>5/10/71</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Calvary</i>		24D. LOCATION (City, town, or county) (State) <i>Pottsville, Penna</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 10 1971</i>		25B. NAME OF REGISTRAR <i>Wm Cook Brooks Towson</i>	
25C. FUNERAL DIRECTOR <i>Wm Cook Brooks Towson</i>		ADDRESS <i>1050 York Road Towson Md 21204</i>	

124
ELIZABETH FARRELL (D)
LORDSTOWN, N.J.
HOSP. PORT POTTSVILLE, PENNA.

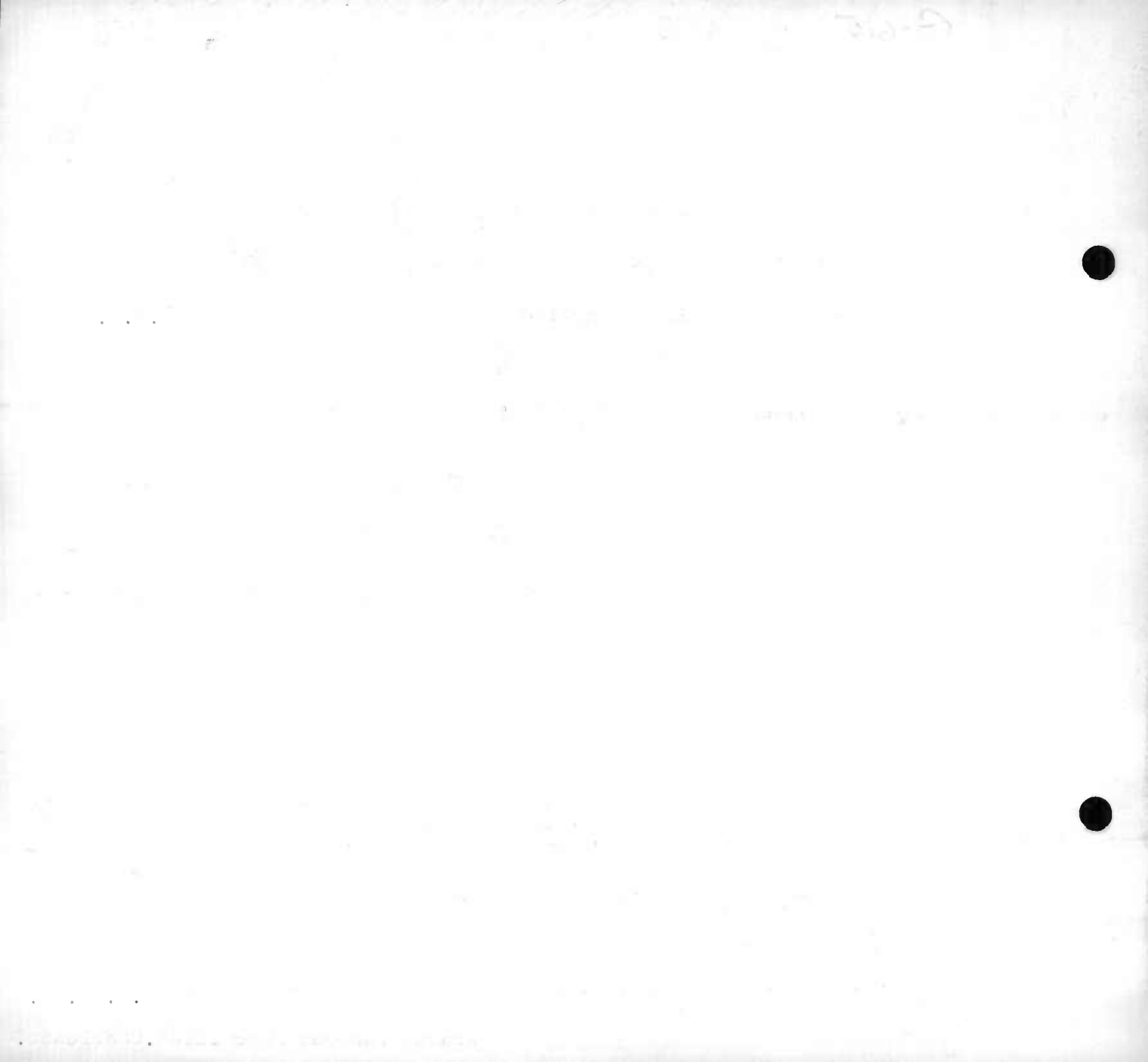
John Ladden (D)
758-01306
Mo

ACVA CMT
CA, ARND.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

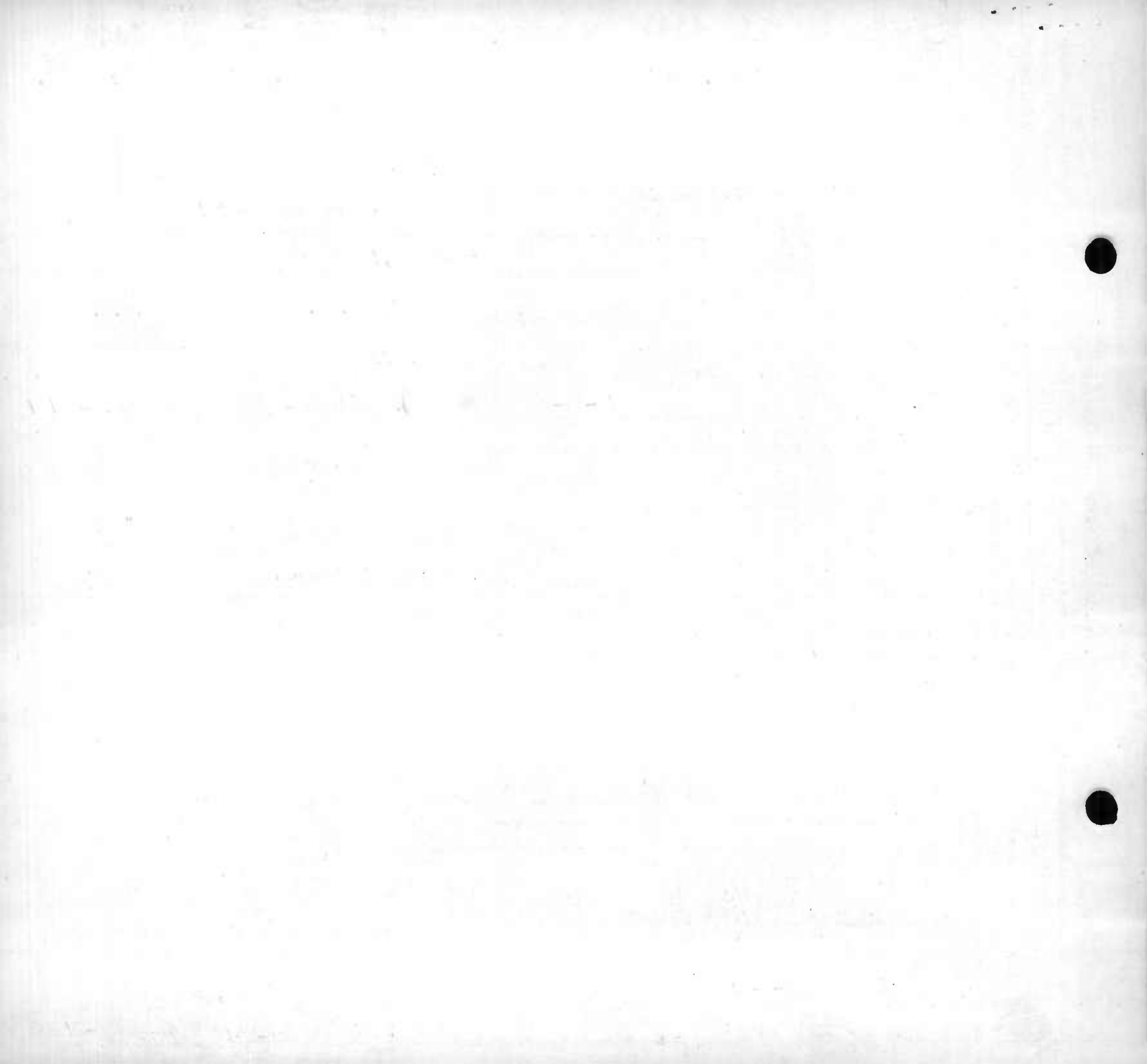
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 4440
G-615 71 4440 BIRTH NO. 1. NAME OF DECEASED (Type or Print) GRIFFIN, ELIZABETH		2. DATE AND HOUR OF DEATH 5-5-71 12 NOON M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Harbor View N.C.C. 1213 Light St. Balto. Md. 21230		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD B. COUNTY MD 9 West Clement St #21230 C. CITY OR TOWN Balto. Md. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 9 W. Clement St. 2301		
5. SEX Female 6. RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-6-91 9. AGE (In years last birthday) 80 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hair Dresser		10B. KIND OF BUSINESS OR INDUSTRY Milton Bayline		
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Henry Stindt		14. MOTHER'S MAIDEN NAME ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no none		16. SOCIAL SECURITY NO. 217-20-0359		
17. INFORMANT Pt's Chart		ADDRESS		
18. CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE Cancer of stomach DUE TO, OR AS A CONSEQUENCE OF: (B) arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: (C) arteriosclerosis generalized		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 5/8/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 1969		
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 1969		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 3/21 1969		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 3/21 1969 to 5/5 1971 that (I) (we) last saw the deceased alive on 5/5 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE ALAN A. MARCH MD		23B. DATE SIGNED 5/6/71		
23C. PHYSICIAN'S NAME (Type) ALAN A. MARCH MD		23D. ADDRESS 2 E. Red St Balto Md		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/8/71		
24C. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		24D. LOCATION (City, town, or county) (Street) Ritchie Highway A.A.Ct.Md.		
25A. DATE REC'D BY HEALTH DEPT. MAY 10 1971		25B. NAME OF REGISTRAR Robert E. Taylor		
25C. FUNERAL DIRECTOR Krause Funeral Home 1216 S. Charles St.		ADDRESS		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

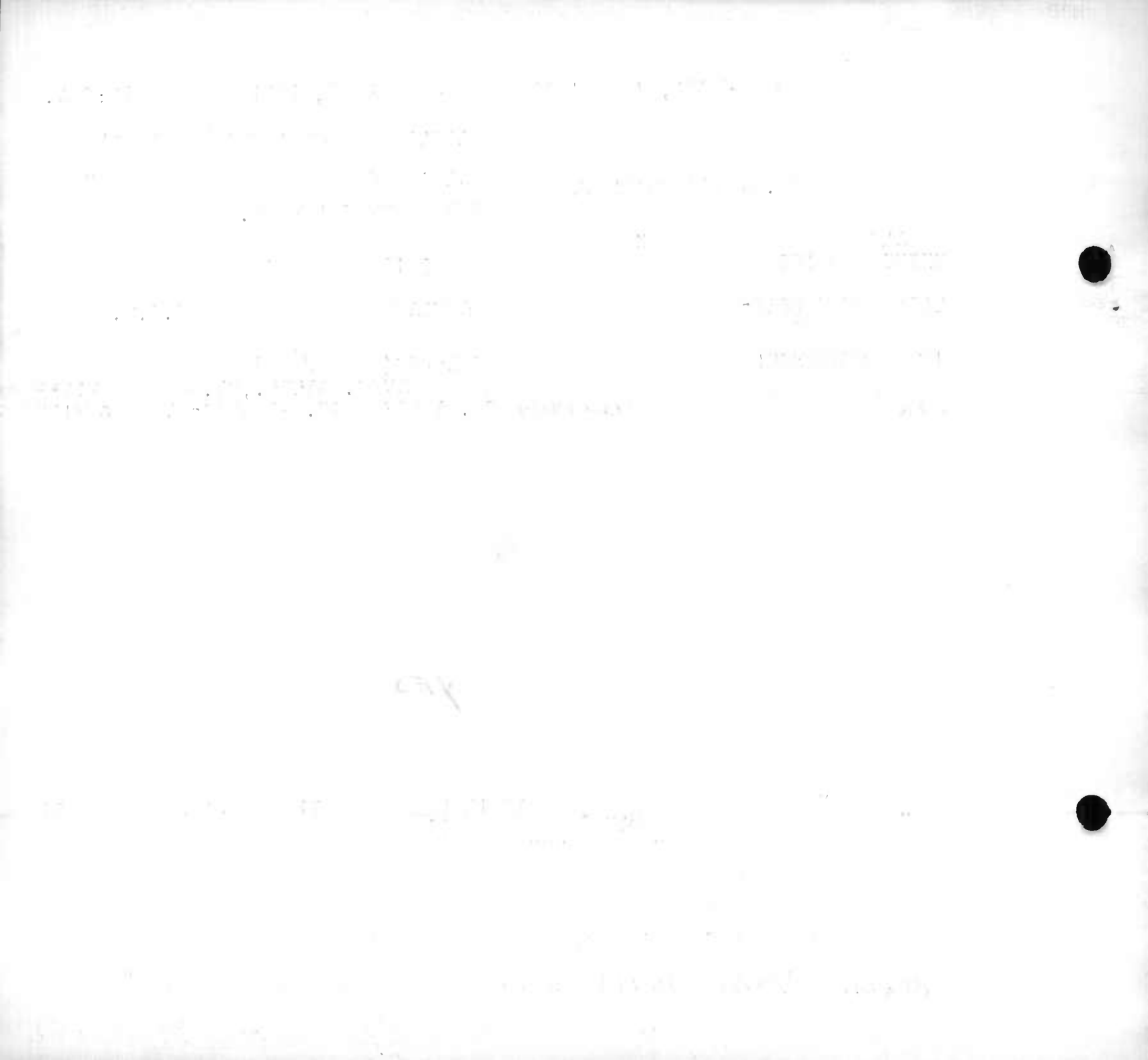
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4441	
S-160 BIRTH NO.		71 4441		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Pauline R. Schiefer			2. DATE AND HOUR OF DEATH May 2, 1971 9:45 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3337 Kenyon Avenue-21213 2633		
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 8, 1902		9. AGE (In years lost birthday) 69
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY Blue Cross		11. BIRTHPLACE (State or foreign country) Nanticoke, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Toadvine		
14. MOTHER'S MAIDEN NAME Edith Turner			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 216-24-2437A			17. INFORMANT Frank G. Schiefer- 3337 Kenyon Ave. - 21213		
18. 410.9+1250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Serious Injuries			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Sudden myocardial infarction (B) DUE TO, OR AS A CONSEQUENCE OF: Old coronary occlusion (C) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic CV disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr 3 years 10 years
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 1958 to May 1971 , that (I) was last saw the deceased alive on April 26 1971 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death.					
23A. SIGNATURE E. P. Coffay Jr			23B. DATE SIGNED 5/4/71		
23C. PHYSICIAN'S NAME (Type) E. P. Coffay Jr			23D. ADDRESS 3100 W Paul St - Balto 18 Md		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-6-71		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery	
24D. LOCATION Baltimore, Maryland		24E. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Rd. -21206			
25A. DATE REC'D BY HEALTH DEPT. MAY 10 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. ADDRESS John C. Miller Inc-6415 Belair Rd. -21206	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4442	
<div style="display: flex; justify-content: space-between;"> D-516 71 4442 CERTIFICATE OF DEATH </div>					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
DOMBROWSKI, JOHN JOSEPH		MAY 6, 1971		12:50A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL		A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER 604 NORTH POINT RD.		F. ZIP CODE 21224			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. UNDER 1 Yr. Months Days
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	08 07 11	59	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
LIFT TRUCK OPERATOR				MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
JOHN DOMBROWSKI		FRANCES ()		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NAK		213-01-4174		AVES. BALTO., MD.	
				ADDRESS 21229 ST. AGNES HOSP. RECORDS-CATON & WILKENS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from APRIL 28 19 71 to MAY 6 19 71 that (X) (we) lost saw the deceased alive on MAY 6 19 71 and that (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (do not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
P. Boonswang, M.D.		5-6-71			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
DR. PRICHA BOONSWANG.		ST. AGNES HOSP.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
BURIAL		5/10/71		HOLLY HILL	
24D. LOCATION (City, town, or county)		24E. DATE REC'D BY HEALTH DEPT.		24F. FUNERAL DIRECTOR	
BALTO. MD.		MAY 10 1971		Council Funeral Home 3007 Macdore	



71 4443

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

71 4443
REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

FRED THOMAS PARHAM

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

May

6,

1971

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
FULL NAME OF HOSPITAL OR INSTITUTION ADDRESS OR LOCATION)

Lutheran Hospital (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

May

6,

1971

8:50 A.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

7-27-01

10. AGE (In years
lost birthday)

69

11. Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

2516 Francis Street

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

maintenance man

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Cynthia

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL
SECURITY NO.

218-18-6442

18. INFORMANT

Gladys Harris

ADDRESS

3316 Edgerton Rd.

19.

4127

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

May 6, 1971

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

5-10-71

24C. NAME of CEMETERY or CREMATORY

Carver Mem. Pk.

24D. LOCATION (City, town, or county)

Laurel, Md.

(State)

25A. DATE REC'D BY HEALTH DEPT

MAY 10 1971

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR V. Bailey ADDRESS

Kelson F.H. 1348 Calhoun Street

71 4444 MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. **71 4444**

BIRTH NO. **70-16860**

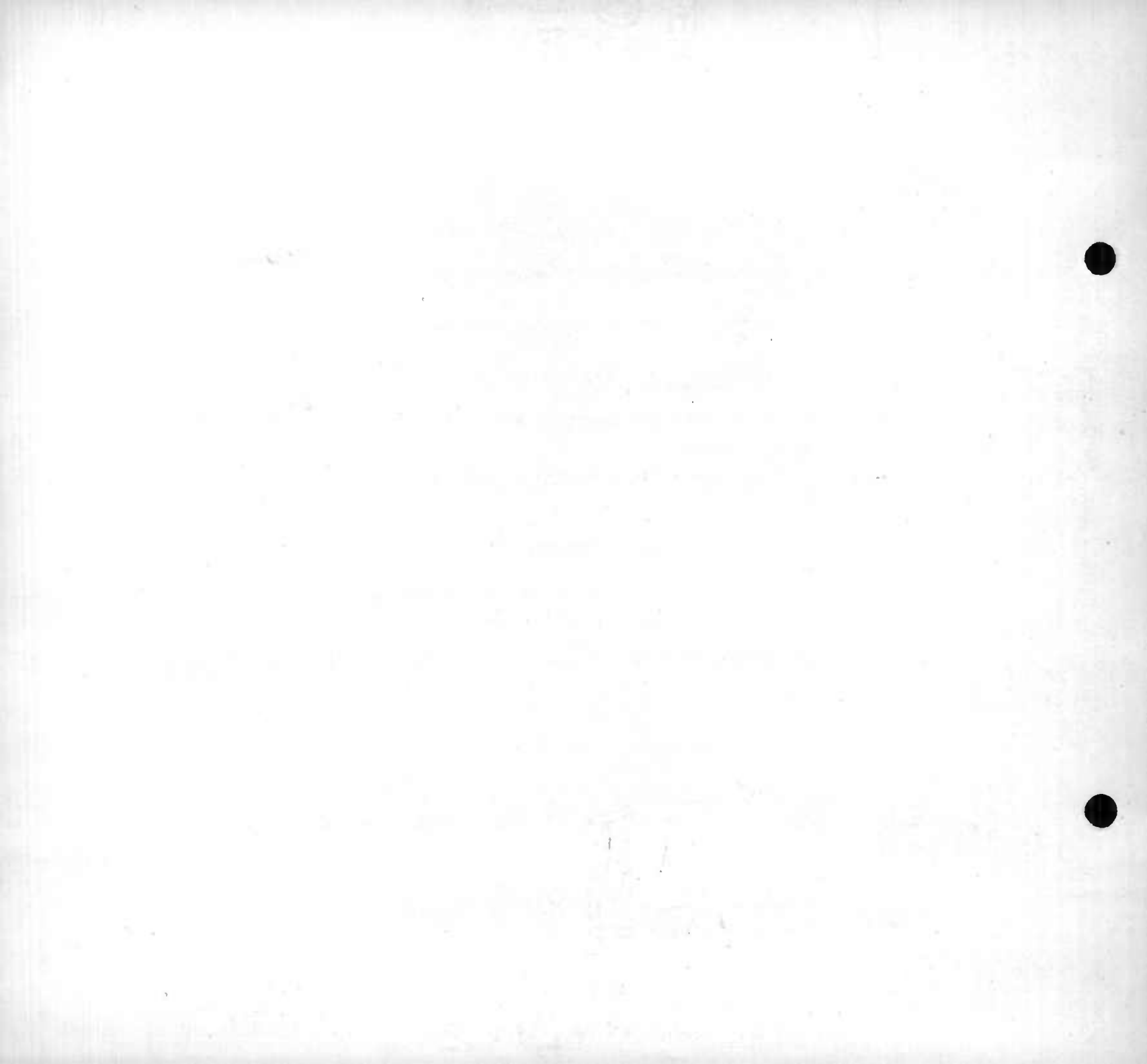
1. NAME OF DECEASED (Type or Print) Shawn Burman		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46 Lutheran Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 5 7 71 11:55 a M.	
6. SEX male		7. RACE colored	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 9-23-70		10. AGE (In years last birthday) 7 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Geraldine Burman		ADDRESS 3313 Dupont Ave.	
19. CAUSE OF DEATH E-911 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ASPHYXIA (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: BOLUS (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15-06	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 3103 W. North Ave.		22F. HOW DID INJURY OCCUR? choked on piece of hot dog	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 5 7 71 11:00a		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner 5/7/71 DATE SIGNED			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-11-71	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 10 1971		25B. NAME OF REGISTRAR Robert E. Faber, M.D.	
25C. FUNERAL DIRECTOR Kelson F.H.		ADDRESS 1348 Calhoun St.	

VALLEY POLICE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

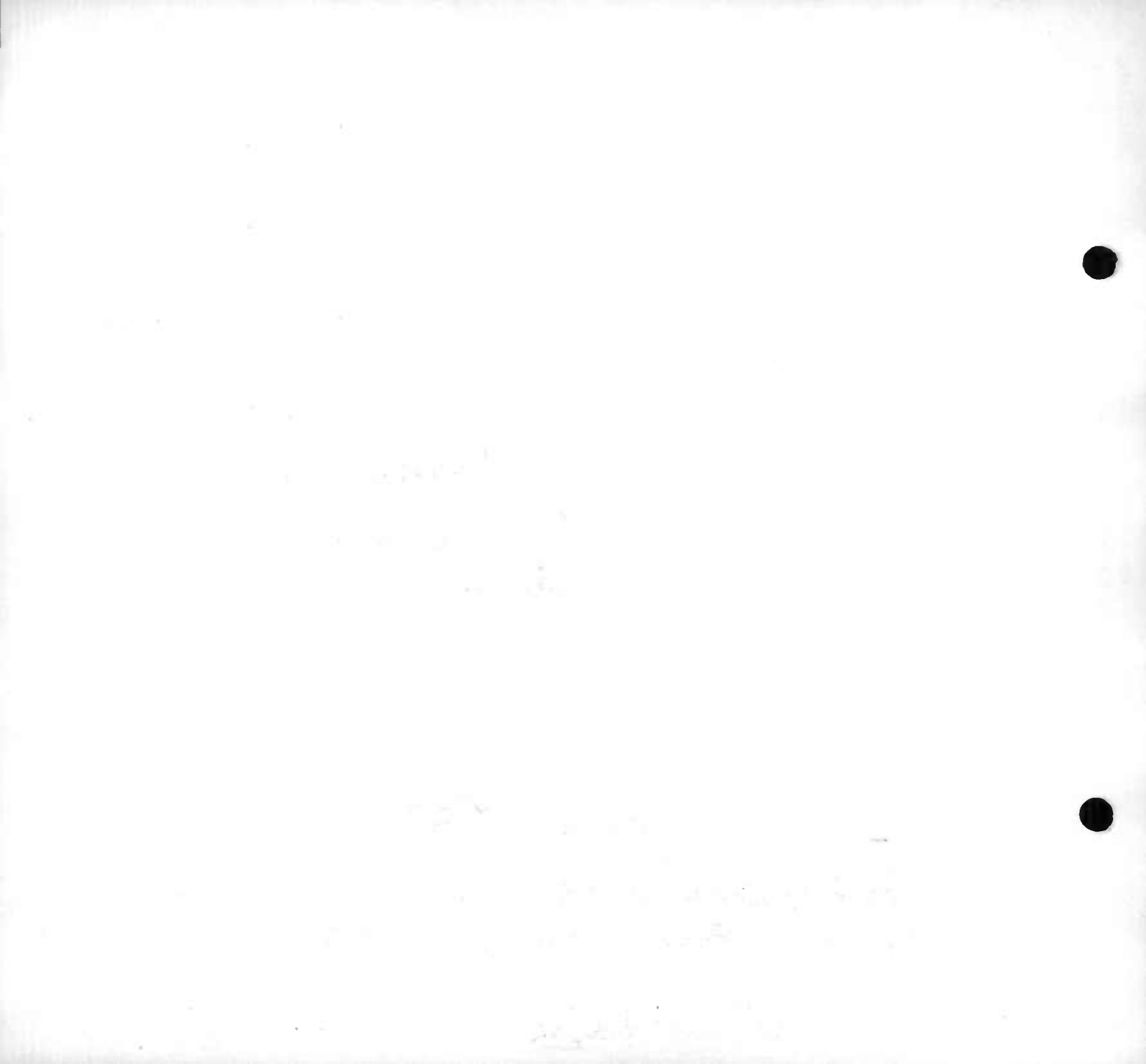
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4445	
BIRTH NO. 71 4445		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) TAYLOR, SARAH J.			2. DATE AND HOUR OF DEATH 5-6-1971 9:45 AM		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL OF MD.			(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore
			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 412 Seagull Ave		2552
5. SEX female	6. RACE negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-20-1911	9. AGE (In years lost birthday) 99	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Laws			14. MOTHER'S MAIDEN NAME Elizabeth Mitchell		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	17. INFORMANT Genevieve Dorsey		ADDRESS same
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: recurrent CVA & marked resp. failure (B) ASCVD & congestive heart failure - 20 days DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days ago.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this <u>hospital</u>) attended the deceased from 4-19-71 19 71 to 5-6 19 71 , that (I) <u>we</u> last saw the deceased alive on 5-6 19 71 and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> <u>did</u> (did not) view the body after death.					
23A. SIGNATURE Myung Duck Ro				23B. DATE SIGNED 5-6-1971	
23C. PHYSICIAN'S NAME (Type) Myung Duck Ro		23D. ADDRESS Lutheran hospital of Maryland.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-7-71		24C. NAME OF CEMETERY or CREMATORY Church Cemetery	
		24D. LOCATION Heathville, Va.		(City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. MAY 10 1971		25B. NAME OF REGISTRAR John E. Taylor		25C. FUNERAL DIRECTOR V. Bailey Kelson F.H.	
				ADDRESS 1348 Calhoun Street	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4446	
BIRTH NO. 71 4446		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Maggie Thomas</u>		2. DATE AND HOUR OF DEATH <u>5-5-71</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>3222 Carlisle Ave.</u>		A. STATE <u>Baltimore, Md.</u> B. COUNTY <u>1537</u>			
5. SEX <u>Female</u>		6. RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>4-18-88</u>		9. AGE (In years last birthday) <u>83</u>		10. UNDER 1 Yr. Months Days 11. UNDER 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Matthews Co., Va.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>William Billups</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Ruff</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT <u>William Gwyn Sr.</u> ADDRESS <u>3222 Carlisle Ave.</u>	
18. <u>4317 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <u>0</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>CEREBRAL HEMORRHAGE</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>CEREBROVASCULAR ARTERIOSCLEROSIS</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>SPONTANEITY</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>JAN</u> 19 <u>71</u> to <u>MAY 5</u> 19 <u>71</u> and that (I) (we) last saw the deceased alive on <u>MAY 5</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Gilbert L. Bamfield M.D.</u>		23B. DATE SIGNED <u>5/6/71</u>		23C. PHYSICIAN'S NAME (Type) <u>GILBERT L. BAMFIELD M.D.</u>	
23D. ADDRESS <u>722 N. Fulton Ave. Balto</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-8-71</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1971</u>	
25B. NAME OF REGISTRAR <u>Robert E. Taylor M.D.</u>		25C. FUNERAL DIRECTOR <u>V.R. Bailey</u>		ADDRESS <u>Kelson Funeral Home 1348 N. Calhoun</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

71 4447

BIRTH NO. **71 4447**

1. NAME OF DECEASED
(Type or Print)

EVANS, OBIE

2. DATE AND HOUR OF DEATH

5/5/71

7:00 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

**Veterans Administration Hospital
3900 Loch Raven Boulevard
Baltimore, Maryland 21218**

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

1615 Calhoun Street

5. SEX

Male

6. RACE

Negro

7. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

6/15/93

9. AGE (In years
last birthday)

77

If Under 1 Yr.
Months: Days

If Under 24 Hrs.
Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Longshoreman

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Portsmouth, Va.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Janius Evans

14. MOTHER'S MAIDEN NAME

Susanna Williams

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown)

Yes

7/31/18 - 7/9/19

16. SOCIAL
SECURITY NO.

217-01-5668

17. INFORMANT

VA Hospital Records

3900 Loch Raven Blvd., Balto., Md 21218

ADDRESS

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

Carcinoma of colon

DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

8 months

(B)

Arteriosclerotic cardiovascular disease

DUE TO, OR AS A CONSEQUENCE OF:

year

(C)

Renal failure

2 weeks

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐

Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from **April 11th** 19 **71** to **May 5th** 19 **71**
that (2) (we) lost saw the deceased alive on **May 5th** 19 **71** and that (3) (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (4) (We) (did) (not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S
NAME (Type)

Attending
Phys. ☐

Med.
Director ☐

Staff
Phys. ☒

23B. DATE SIGNED

7 May 71

23D. ADDRESS

**3900 Loch Raven Boulevard
Baltimore, Maryland 21218**

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

5-11-71

24C. NAME OF CEMETERY OR CREMATORY

St. Auburn Cem.

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

MAY 10 1971

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

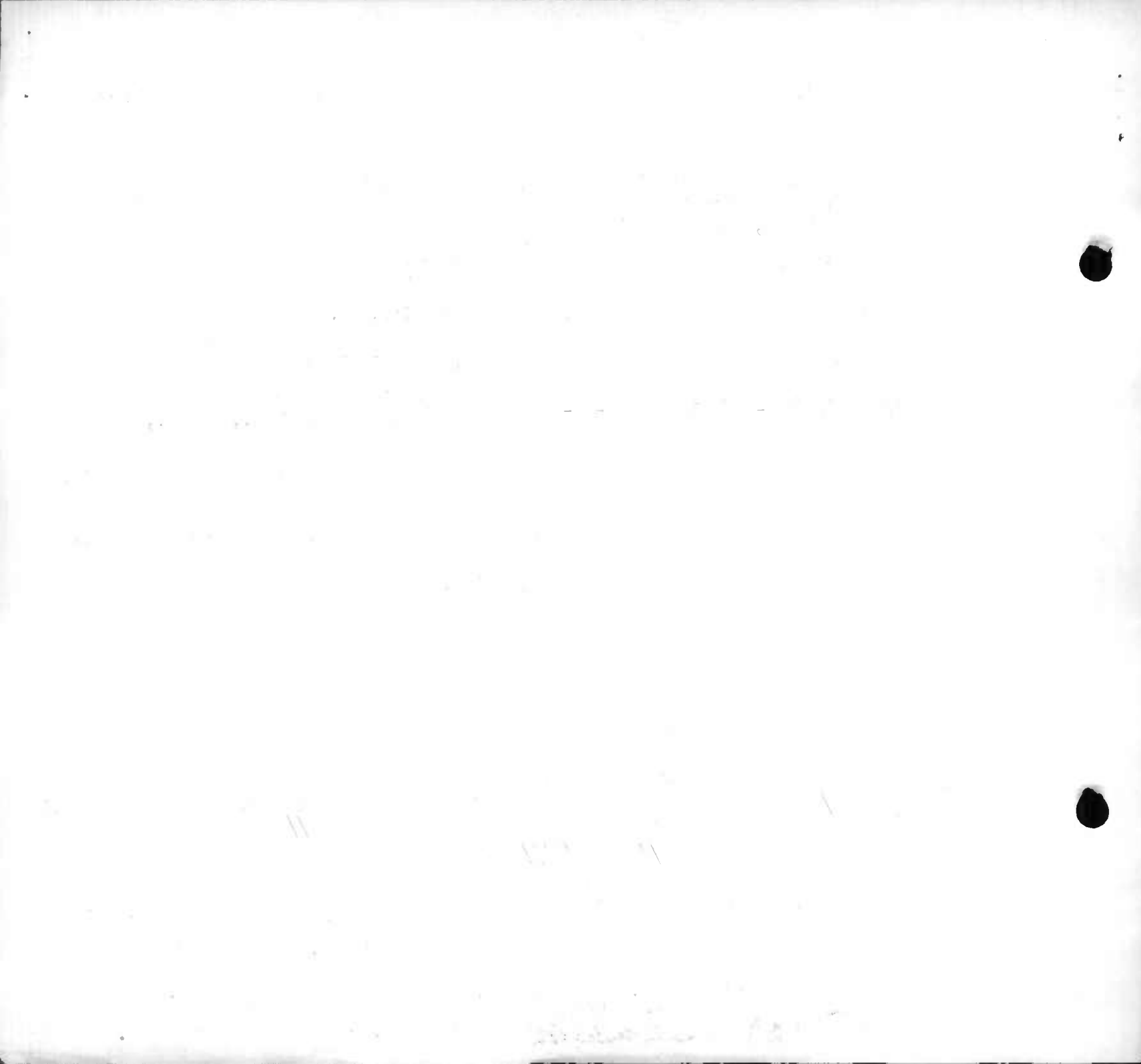
25C. FUNERAL DIRECTOR

Kelson F.H.

V. ailey

ADDRESS

1348 Calhoun St.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Earla V. Clements

2. DATE
OF
DEATHKnown ☒
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
HOSPITAL ADDRESS OR LOCATION)
OR INSTITUTION

1401 Pennsylvania Ave.

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

5

7

71

6:37 a.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

6. SEX

female

7. RACE

colored

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

6-15-10

10. AGE (In years
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1401 Pennsylvania Ave.

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James Butler

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

domestic

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Eva Campbell

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL
SECURITY NO.

215-12-5070

18. INFORMANT

Alice Parker

ADDRESS

1347 Carey St.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)Hypertensive and arteriosclerotic cardio-
vascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A.

DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A.

EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

22D.

TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner H. Spitz, M.D.

Deputy Chief Medical Examiner

DATE SIGNED

5/7/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

5-11-71

24C. NAME OF CEMETERY or CREMATORY

Arbutus Mem. Pk.

24D. LOCATION (City, town, or county)

Balto. Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

MAY 10 1971

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Kelson F.H.

ADDRESS

1348 Calhoun Street

VALLEY POST

25 CENT

NOV 9 1938

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-152 71 4449		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 71 4449	
1. NAME OF DECEASED (Type or Print) <u>AGUIA C. EVANS</u>		2. DATE AND HOUR OF DEATH <u>5-16-71</u> <u>12 15</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Lutheran Hospital of Md.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY _____			
5. SEX <u>Female</u>		6. RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>6-4-10</u>		9. AGE (In years last birthday) <u>60 yrs.</u>		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>PICKETT COFFEY</u>			
14. MOTHER'S MAIDEN NAME <u>ELIZABETH MOORE</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>243-16-7716</u>		17. INFORMANT ADDRESS <u>MRS ALMA DIXON 813 E. COLDSRING LA</u>			
18. <u>450X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>PULMONARY EMBOLISM</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>PULMONARY EMBOLISM</u>			
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>ACUTE CHOLECYSTITIS</u>					
19A. DATE OF OPERATION <u>5-10-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) <u>5-6-1971</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <u>5-3-1971</u> to <u>5-6-1971</u> that (X) (we) last saw the deceased alive on <u>12:15pm on 5-6-1971</u> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>AJAZ ARAIN MD</u>		23B. DATE SIGNED <u>5-6-1971</u>		23C. PHYSICIAN'S NAME (Type) <u>AJAZ ARAIN</u>	
23D. ADDRESS <u>LUTHERAN HOSPITAL OF MD, 750 ASHBURTON ST. BALTO 21216</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>5-10-71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>ARBUTUS MEM PARK</u>	
24D. LOCATION <u>BALTO. MD.</u>					
25A. DATE RECEIVED BY HEALTH DEPT. <u>MAY 10 1971</u>		25B. NAME OF REGISTRAR <u>WM. C. MARCH</u>		25C. FUNERAL DIRECTOR ADDRESS <u>928 E. NORTH AVE</u>	

1204 Bloomingdale Rd.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
W-452		4450		71 4450	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH			
Matthew Williams		Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD			
2621 Cecil Ave.		Month Day Year Hour 5 7 71 10:40 a.m.			
6. SEX		7. RACE		5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
male	colored	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		A. STATE Maryland B. COUNTY	
9. DATE OF BIRTH	10. AGE (In years last birthday)	C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
3-15-94	77	Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country)		E. STREET AND NUMBER		907	
North Carolina		2621 Cecil Ave.			
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
John Williams		Hester		Laborer	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
Laborer		Hester		17. SOCIAL SECURITY NO. 215-24-2599	
17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS	
215-24-2599		Callie Nixon		2621 Cecil Ave.	
19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)	
				no	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER			
Werner U. Spitz, M.D.		ASSOCIATE MEDICAL EXAMINER			
Deputy Chief Medical Examiner				5/7/71	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		5-10-71		Mt Calvary Cemetery	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR		24F. ADDRESS	
Anne Arundel Cty., Md.		Wm C March		928 E. North Ave.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. ADDRESS	
MAY 10 1971		Robert E. Taylor, M.D.			

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		E. GEORGE WILSON JR.		2. DATE OF DEATH		Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		3. DATE PRONOUNCED DEAD		May 9, 1971 1:30 A.M.	
6. SEX		7. RACE		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN D. INSIDE CITY LIMITS?	
Male		Negro		Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years lost birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
3-29-40		31		North Carolina		George E. Wilson Sr.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
Steel Worker				Thelma		No	
17. SOCIAL SECURITY NO.		18. INFORMANT		19. CAUSE OF DEATH		ADDRESS	
239-60-4634		Mrs. Gladys Wilson		Multiple Traumatic Injuries (Crushed Chest)		20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		23. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		24. AUTOPSY? (Yes or No)	
		Street		33rd Street and The Alameda		yes	
25. TIME (Month) (Day) (Year) (Hour)		26. INJURY OCCURRED		27. HOW DID INJURY OCCUR?		28. TIME OF INJURY (APPROX.)	
5-9-71 1:15 A.		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Passenger in auto fixed object collision		5-9-71	
29. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		30. ACTUAL SIGNATURE EXAMINER'S NAME (Type)		31. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		32. DATE SIGNED	
Ronald N. Kornblum, M.D.						5/9/71	
33A. BURIAL CREMATION, REMOVAL (Specify)		33B. DATE		33C. NAME of CEMETERY or CREMATORY		33D. LOCATION (City, town, or county) (State)	
Burial		5/13/71				Ayden, N.C.	
34. DATE REC'D BY HEALTH DEPT.		35. NAME OF REGISTRAR		36. FUNERAL DIRECTOR		37. ADDRESS	
MAY 10 1971				Wm C. March		928 E. North Ave.	

5-22-40

North Carolina

State of North Carolina

George H. Wilson Sr.

Thomas

855-24-1001 Mrs. Gladys Wilson, 1001 E. 10th St.

WALTER P. HARRIS

Walter P. Harris

Walter P. Harris, 825 E. 10th St.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. [REDACTED] 4452	
S-316 71 4452		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>MAGDALENA STUPRICH</i>		2. DATE AND HOUR OF DEATH <i>5/6/71</i> <i>9:30</i> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md</i> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION <i>90 Melchor Nursing Home</i> <i>2327 N. Charles St.</i>		C. CITY OR TOWN <i>4024 Orleans St</i> <i>Balt md</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Female</i>	6. RACE <i>Caucasian</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 7, 1879</i>	9. AGE (in years last birthday) <i>91 yrs</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home maker</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Hungary</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Reben Wiesner</i>		14. MOTHER'S MAIDEN NAME <i>Elisabeth</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Regina Lehman</i> ADDRESS <i>1109 Chasaco Ave</i>	
18. <i>412.41</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>Arteriosclerotic Cardiovascular Disease</i>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerotic Cardiovascular Disease</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>several years</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1967</i> <i>19</i> to <i>May</i> <i>1971</i> , that (I) (we) lost saw the deceased alive on <i>May</i> <i>1971</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Loy M. Zimmerman M.D.</i>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <i>Loy M. Zimmerman M.D.</i>	
23D. ADDRESS <i>3202 Hartford Rd. Baltimore, Md</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>5-10-71</i>		24C. NAME OF CEMETERY or CREMATORY <i>OAK Lawn Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>MAY 10 1971</i>		25B. NAME OF REGISTRAR <i>John E. Talley M.D.</i>		25C. FUNERAL DIRECTOR <i>Phyllis E. Green</i> ADDRESS <i>124 Chasaco Ave</i>	

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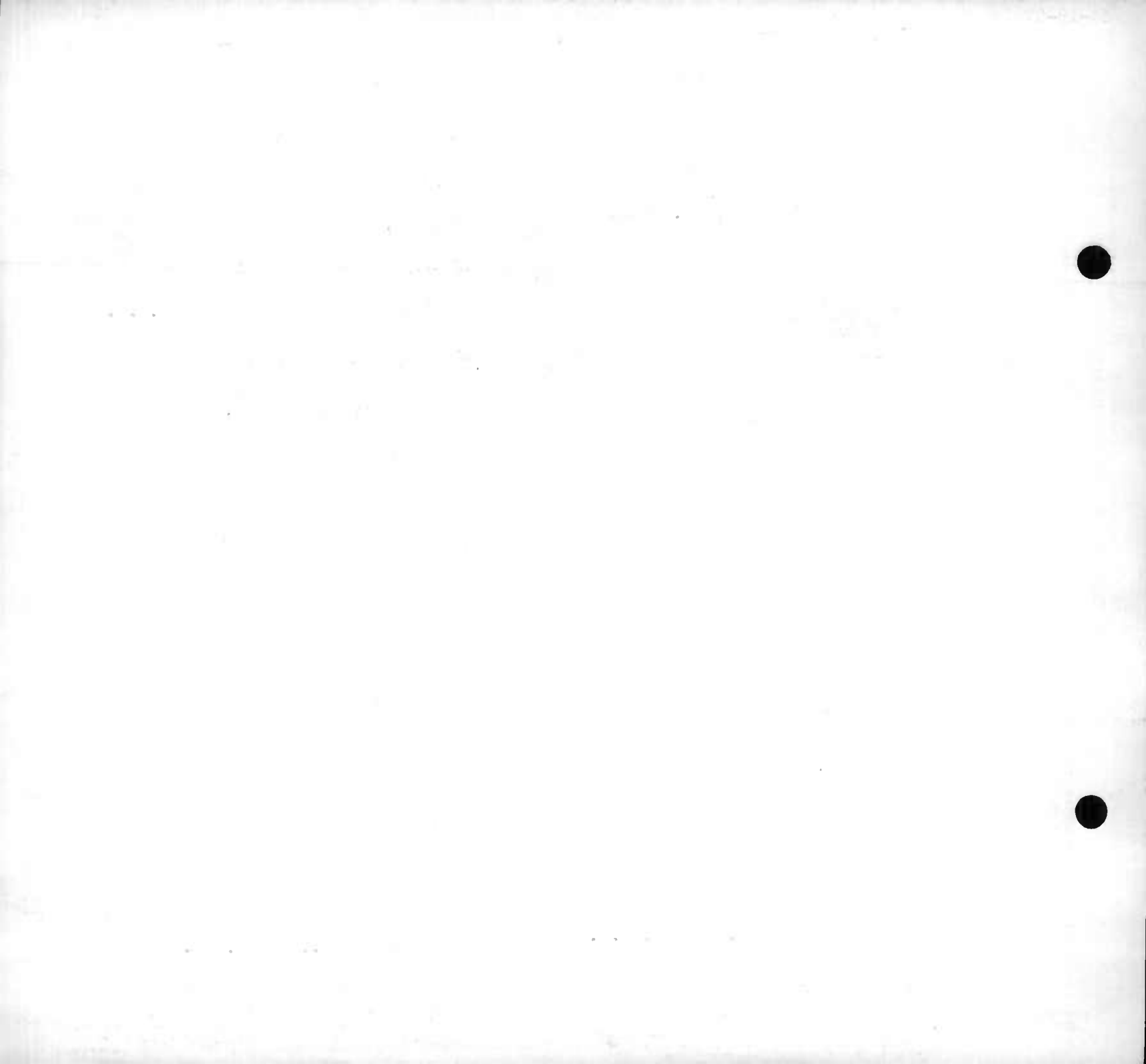
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1891

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>T-526 71 4453</p> <p style="text-align: center;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="text-align: center;">CERTIFICATE OF DEATH</p>		<p>71 4453</p> <p>REG. NO.</p>	
<p>BIRTH NO.</p> <p>1. NAME OF DECEASED (Type or Print) <u>TANKERSLEY BESSIE L.</u></p>		<p>2. DATE AND HOUR OF DEATH <u>5/4/71</u> <u>11:25</u> P.M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Luttervan Hospital of MD.</u> <u>46 Balto. md. 21216</u></p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u></p>	
<p>5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>3/12/87</u> 9. AGE (In years last birthday) <u>84</u></p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY <u>Stewart & Co.</u></p>	
<p>11. BIRTHPLACE (State or foreign country) <u>Md.</u></p>		<p>12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u></p>	
<p>13. FATHER'S NAME <u>John M. Ryan</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>Fannie L. Hyle</u></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u></p>		<p>16. SOCIAL SECURITY NO. <u>214-14-7204</u></p>	
<p>17. INFORMANT <u>Roland L. Tankersley, jr.</u></p>		<p>ADDRESS <u>4917 Challedon Rd.</u></p>	
<p>18. <u>4/23/71</u> CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Congestive heart failure</u></p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>arteriosclerotic heart disease</u></p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF: <u></u></p> <p>(C) <u></u></p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u></p>	
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION <u>2</u></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u></u></p>	
<p>20A. AUTOPSY? (Yes or No) <u>yes</u></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u></u></p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u></u></p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u></u></p>		<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u></u></p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR? <u></u></p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <u>4/26</u> 19<u>71</u> to <u>5/4</u> 19<u>71</u> that (I) (we) last saw the deceased alive on <u>5/4</u> 19<u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <u>E. M. Gayoso</u></p>		<p>23B. DATE SIGNED <u>5/4/71</u></p>	
<p>23C. PHYSICIAN'S NAME (Type) <u>ELMO M. Gayoso</u></p>		<p>23D. ADDRESS <u>Luttervan Hosp. Balto. 21216</u></p>	
<p>24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u></p>		<p>24B. DATE <u>5-7-1971</u></p>	
<p>24C. NAME OF CEMETERY or CREMATORY <u>Mt. Olivet</u></p>		<p>24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1971</u></p>		<p>25B. NAME OF REGISTRAR <u></u></p>	
<p>25C. FUNERAL DIRECTOR <u>J. Howard Strong</u></p>		<p>ADDRESS <u>North Ave + Hillman St.</u></p>	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

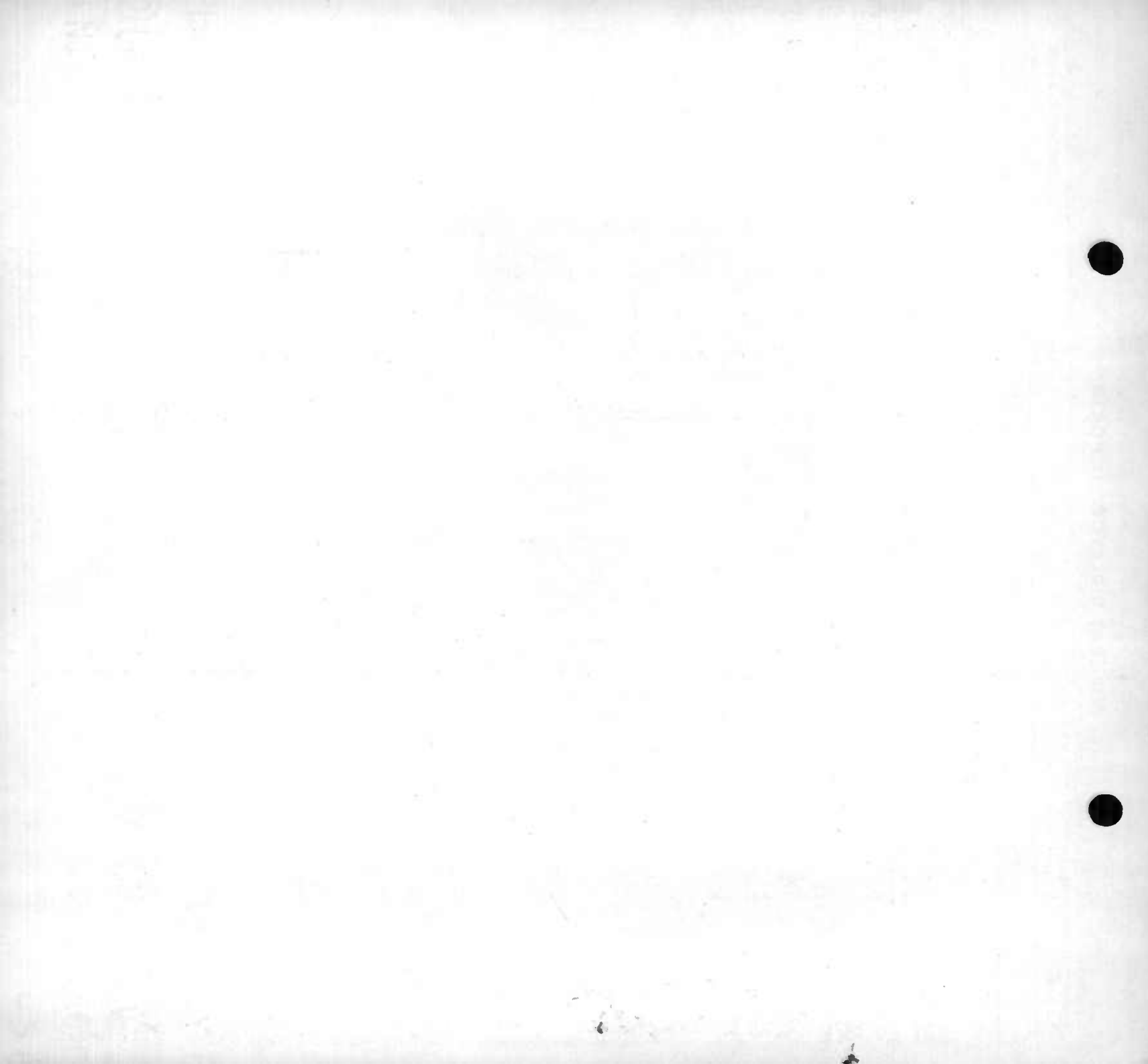
M-445 71 4454		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 4454	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		Elmer Mulholland		2. DATE AND HOUR OF DEATH May 6, 1971 12:19 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Maryland Talbot		C. CITY OR TOWN D. INSIDE CITY LIMITS?	
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Md. 21224		Wittman		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. CITIZEN OF WHAT COUNTRY?	
9-13-09		61		U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
EUROPEAN				Pennsylvania	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		17. INFORMANT	
GEORGE A. MULHOLLAND		ELIZABETH FIELD		4940 Eastern Avenue	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		BCH Records: Baltimore, Maryland 21224	
Yes		WW II			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		1 week	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		2 years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from April 3, 1971 to April 6, 1971		that (I) (we) last saw the deceased alive on April 5, 1971 and that (I) (my) (our) opinion/death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED			
Thomas R. Griggs, M.D.		April 6, 1971			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Thomas R. Griggs, M.D.		Baltimore City Hospitals 4940 Eastern Ave., Balto. Md. 21224			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		May 7, 1971		Mt. Holly Cemetery	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
Baltimore, Md.		May 10, 1971		John E. Taylor, M.D.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
May 10, 1971		John E. Taylor, M.D.		O'Leary Funeral Home, 2340 N. N. N.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4455	
<div style="display: flex; justify-content: space-between;"> D-252 71 4455 71 4455 </div>					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) THEODORE DIACUMAKOS			2. DATE AND HOUR OF DEATH 5/3/71 2¹⁰ P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 90 Gould Convalesarium			A. STATE Maryland		B. COUNTY Baltimore
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER 217 Linden Avenue 5300					
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-25-96	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restauranteur Food			11. BIRTHPLACE (State or foreign country) Greece		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Stavro Diacumakos			14. MOTHER'S MAIDEN NAME Eleni Surges		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 215-01-0506		17. INFORMANT ADDRESS Mrs. Lillian Diacumakos 217 Linden Avenue, Baltimore, Md.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 519.317250.9 (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE Pneumonia DUE TO, OR AS A CONSEQUENCE OF: (B) Chronic Obstructive Pulmonary Disease DUE TO, OR AS A CONSEQUENCE OF: (C) Chronic Obstructive Pulmonary Disease		
MEDICAL CERTIFICATION					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Chronic Obstructive Pulmonary Disease, Chronic Bronchitis, Emphysema, Arteriosclerosis, Hypertension, Chronic Kidney Disease, Diabetes					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/12/1920 to 5/3/1971 , that (I) (we) last saw the deceased alive on 4/29/1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED 5/3/71	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-6-71		24C. NAME of CEMETERY or CREMATORY Greek Orthodox Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. MAY 10 1971			
25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR ADDRESS Nicholas T. Matthews 3021 Eastern Ave, Baltimore, Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 4456		71 4456	
BIRTH NO.				L-152		71 4456	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Levanis, Nicholas</u>				2. DATE AND HOUR OF DEATH <u>5-3-71</u> <u>10:00 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Sinai Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3715 Falls Rd, #11</u> <u>1306</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1886</u>	9. AGE (In years last birthday) <u>85</u>	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Engineering</u>			
11. BIRTHPLACE (State or foreign country) <u>Greece</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>215-01-4326</u>			
17. INFORMANT <u>medical record</u>				ADDRESS			
18. <u>4-12-41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>C.V.A.</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Anterograde cardiovascular years</u> DUE TO, OR AS A CONSEQUENCE OF: <u>disease</u> (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Pneumonia</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>March 21</u> 19 <u>71</u> to <u>May 3</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>May 3</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Marcia Waterburg, M.D.</u>				23B. DATE SIGNED <u>5-3-71</u>		23C. PHYSICIAN'S NAME (Type) <u>DEGREE</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>5-6-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Greek Orthodox Cemetery Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1971</u>				25B. NAME OF REGISTRAR <u>Palmer E. Taber, M.D.</u>		25C. FUNERAL DIRECTOR <u>Nicholas T. Matthews</u> ADDRESS <u>3021 Eastern Ave., Baltimore, Md.</u>	

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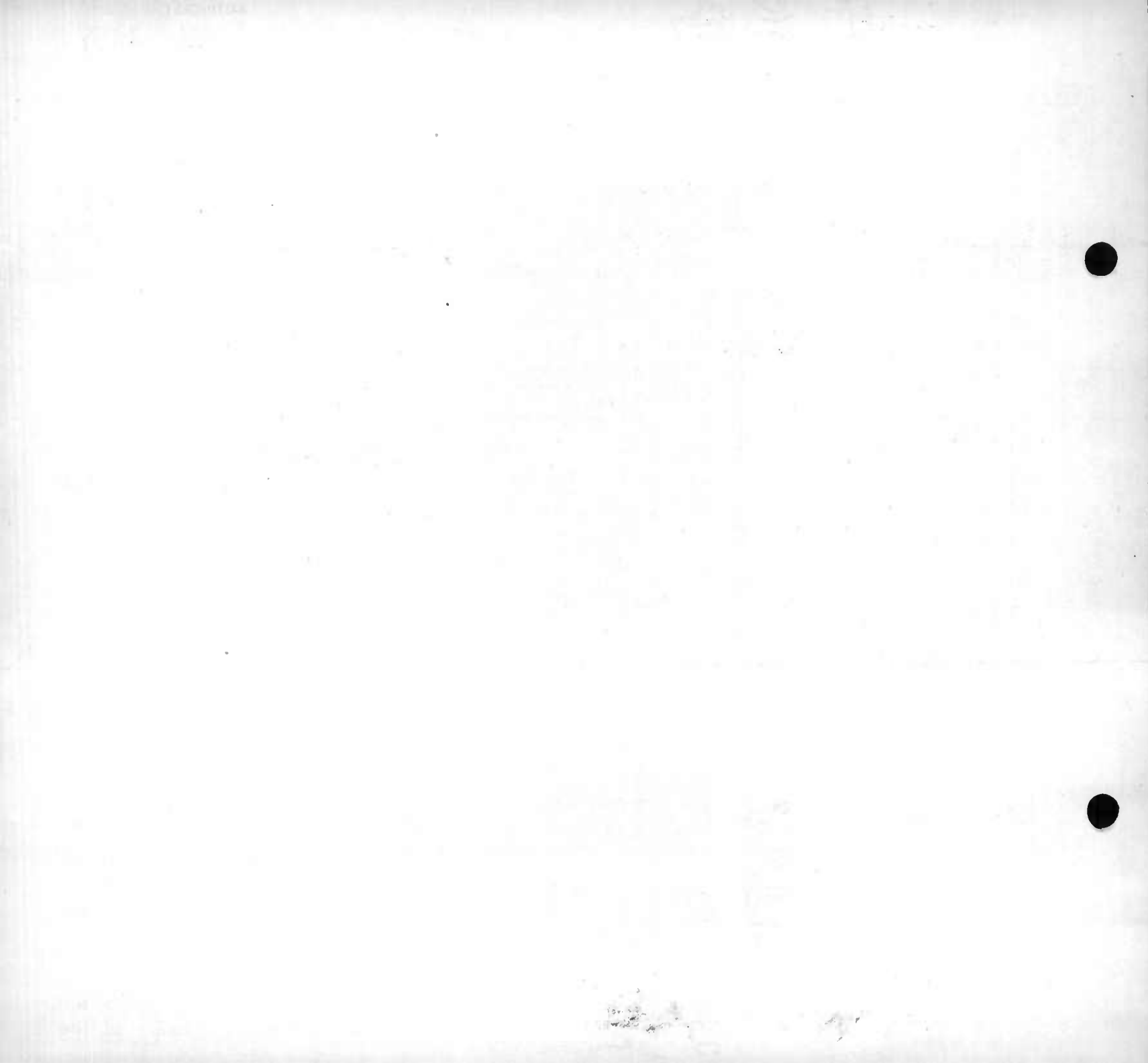
Lat 19 50 N Long 155 10 W

Lat 19 50 N Long 155 10 W

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4457	
<div style="display: flex; justify-content: space-between;"> H-520 71 4457 </div>					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <i>Henrietta L Haines</i>			2. DATE AND HOUR OF DEATH <i>May 4 1971</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>95 East Ave Balto 24</i>			A. STATE <i>Md.</i> B. COUNTY		
			C. CITY OR TOWN <i>Balto</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <i>905 Pontiac Ave Balto Md. 25 2544</i>		
5. SEX <i>F</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 4, 1921</i>	9. AGE (In years last birthday) <i>49</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>? Greenstreet</i>		14. MOTHER'S MAIDEN NAME <i>Kathryn Vonder Boch</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT ADDRESS <i>Howard E Haines 905 Pontiac Ave 25</i>	
18. <i>72.3.91</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH <i>None</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>None</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <i>5/3/71</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>5/3</i> 19 <i>71</i> to <i>5/4</i> 19 <i>71</i> , that (I) (we) last saw the deceased alive on <i>5/3</i> 19 <i>71</i> and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>J.H. Goodman</i>			23B. DATE SIGNED <i>5/6/71</i>		23C. PHYSICIAN'S NAME (Type) <i>J.H. Goodman</i>
23D. ADDRESS <i>9 S. Hyblum Ave</i>			24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		
24B. DATE <i>5/10/71</i>			24C. NAME OF CEMETERY or CREMATORY <i>Cedar Hill Cemetery</i>		
24D. LOCATION (City, town, or county) (State) <i>Rithie Hwy Balto 25</i>			25A. DATE REC'D BY HEALTH DEPT. <i>MAY 10 1971</i>		
25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR ADDRESS <i>Marully Funeral Home 237 Patapsco Ave 25</i>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-630 71 4458		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 4458	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Rosa B. SHRETT		5/6/71 9 ³⁴ P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Gould Convalesarium				A. STATE Md.	
				B. COUNTY Baltimore	
90				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3132 Cornwall Road 5300					
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 31, 1883	9. AGE (In years last birthday) 87
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Va.	
13. FATHER'S NAME Edwin Butler		14. MOTHER'S MAIDEN NAME Mary Douglas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Mildred Schrufer 3132 Cornwall Rd.	
18. 412.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, pneumonia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Anterolateral Heart Dissection</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Cerebral Pneumonia, Congestive Heart Failure</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/3/71 to 5/6/71, that (I) (we) lost saw the deceased alive on 5/4/71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Albert B. Bradley</i> DEGREE				23B. DATE SIGNED 5/6/71	
23C. PHYSICIAN'S NAME (Type) Albert B. Bradley DEGREE				23D. ADDRESS 4900 Belair Rd.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-8-1971		24C. NAME of CEMETERY or CREMATORY Woodlawn	
				24D. LOCATION (City, town, or county) (State) Woodlawn Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 10 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR G. Howard Strong 3207 W. North Ave.,	

Edwin Butler

Mary Douglas

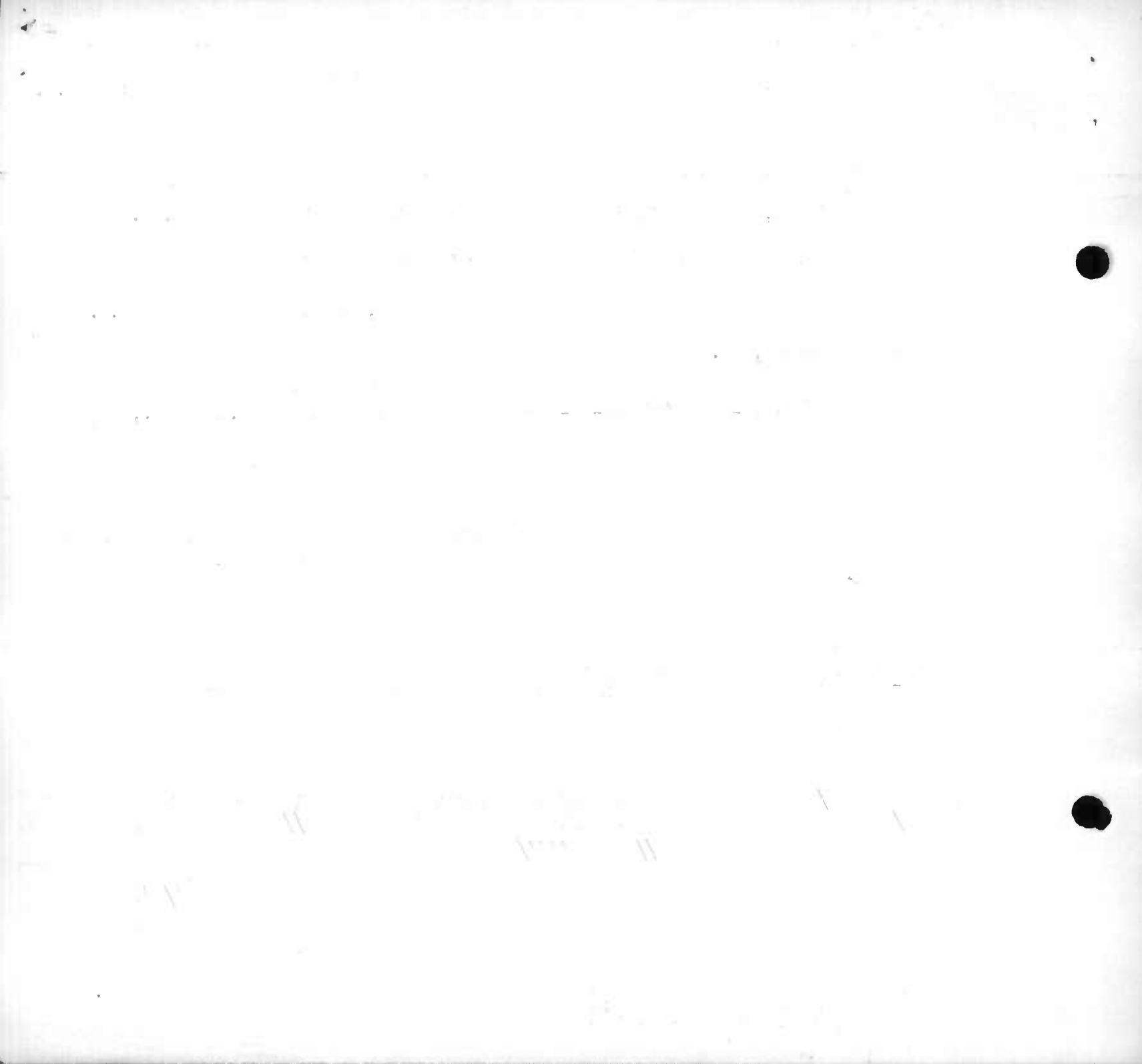
no

Mrs. Mildred Schreier 3132 Cornwall Rd.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4459	
S-660 71 4459		BIRTH NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
SCHERER, Carroll John		5/5/71		1:25 P.M. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218		Maryland			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Bartender		Tavern		3/18/17	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (In years last birthday)	
Carroll Scherer, Sr.		Edith Eaves		54	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country)	
Yes		216-07-5406		Baltimore, Maryland	
17. INFORMANT		12. CITIZEN OF WHAT COUNTRY?			
VA Hospital Records		U.S.A.			
17. ADDRESS		3900 Loch Raven Blvd., Balto., Md 21218			
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		2 hours	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Metastatic far advanced Carcinoma of DUE TO, OR AS A CONSEQUENCE OF: the right lung		6 months	
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
4/3-4/28/71		biopsy of intraspinal tumor		YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				Yes	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22. I certify that (1) (this hospital) attended the deceased from March 2nd 19 71 to May 5th 19 71 that (1) (we) lost saw the deceased alive on May 5th 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
M. Sank		5/6/71			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		3900 Loch Raven Boulevard Baltimore, Maryland 21218			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
burial		5/10/71		Cedar Hill Cemetery	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
Rithie Hwy Balto 25 Md.		MAY 10 1971		John E. Smith, M.D.	
25A. FUNERAL DIRECTOR		25B. ADDRESS			
McCully Funeral Home		237 Patapsco Ave 25			



BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

B-200 71 4460 REG. NO. 71 4460

BIRTH NO.

1. NAME OF DECEASED (Type or Print) AUGUST BECK		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (Full name of hospital or institution, street address or location) 43 SOUTH BALTO. GENERAL HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour May 4, 1971 8:14 P. M.	
6. SEX Male		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH April 6, 1900	10. AGE (In years lost birthday) 71 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	E. STREET AND NUMBER 3727 Brooklyn Avenue	
11. BIRTHPLACE (State or foreign country) Balto Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Ret Team Clerk		14B. KIND OF BUSINESS OR INDUSTRY B.O.R.R.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		15. MOTHER'S MAIDEN NAME Unknown	
17. SOCIAL SECURITY NO.		18. INFORMANT Alvina Beck as above	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type): Ronald N. Kornblum, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 5/5/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 5/8/71	24C. NAME OF CEMETERY or CREMATORY Oaklawn Cemetery	24D. LOCATION (City, town, or county) (State) Balto 22 Md.
25A. DATE REC'D BY HEALTH DEPT. MAY 10 1971	25B. NAME OF REGISTRAR Robert E. Taylor, R.D.	25C. FUNERAL DIRECTOR ADDRESS McCully Funeral Home 237 Patapsco Ave	

V.S. 153

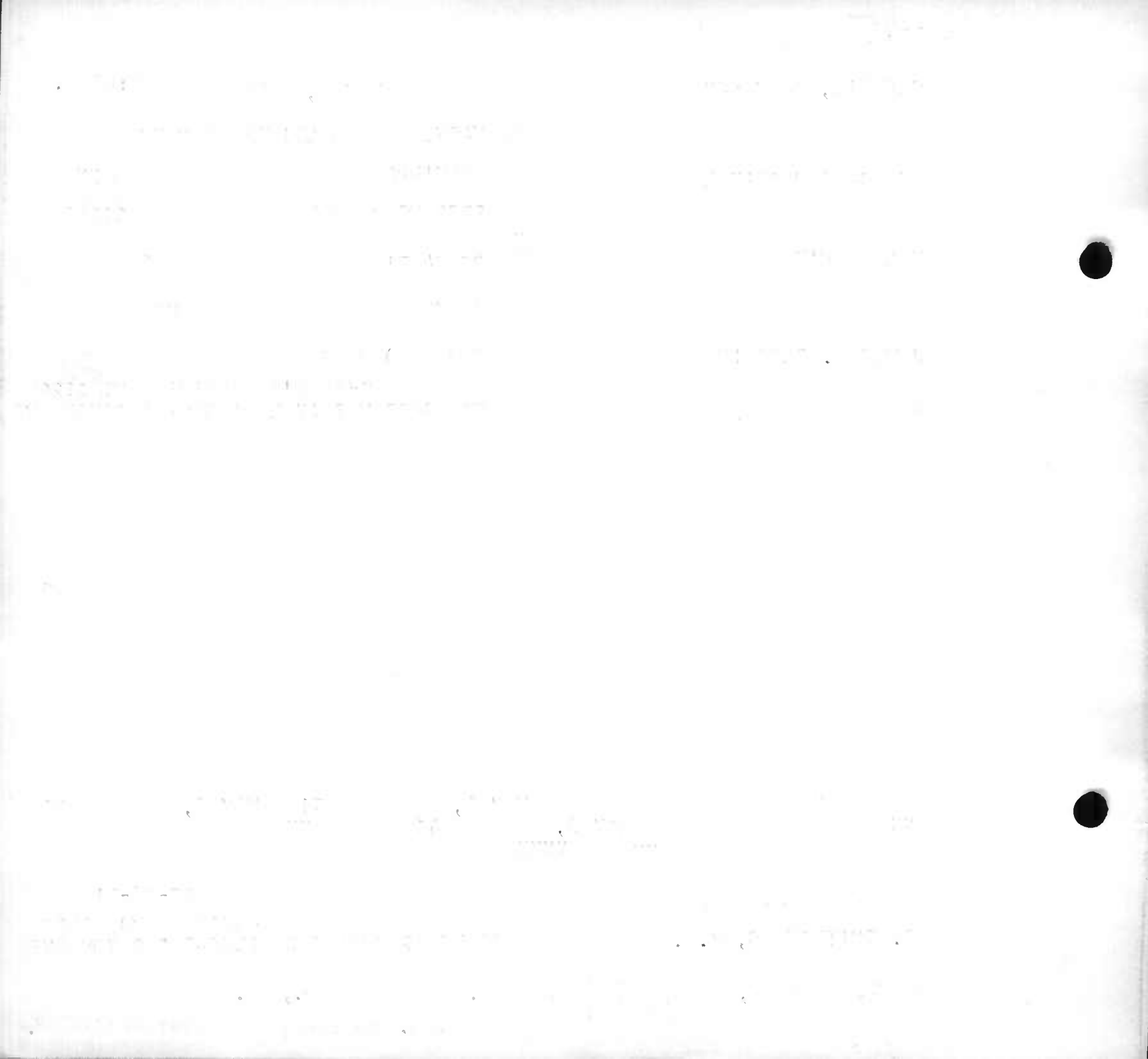
5-17-71

M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

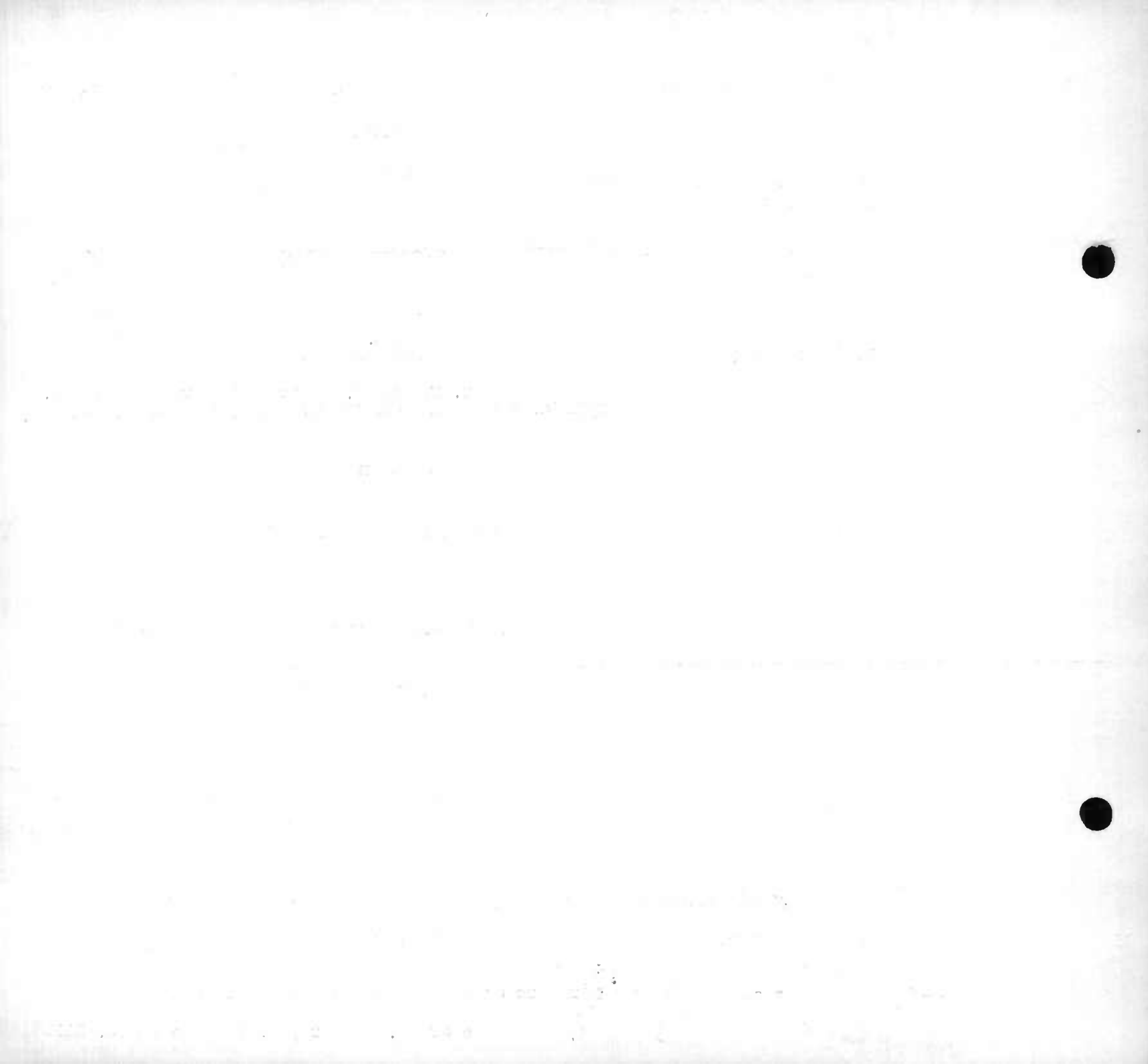
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 4461</u>
C-415 BIRTH NO. <u>71-07534</u> 4461		2. DATE AND HOUR OF DEATH <u>MAY 6, 1971</u> <u>6:00 A.</u> M.		
1. NAME OF DECEASED (Type or Print) CLOPEIN, BABY BOY		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD ST AGNES HOSPITAL <u>40</u>		
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE COUNTY</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>3753 MC DOWELL LANE</u> <u>21227</u>		5. SEX <u>MALE</u> 6. RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>05 04 71</u> 9. AGE (In years last birthday) <u>2</u> 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>JAMES A. CLOPEIN</u>		14. MOTHER'S MAIDEN NAME <u>(WUNDER) JANE</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. 17. INFORMANT <u>RECORD'S BALTIMORE MD 21229</u> <u>ST AGNES HOSPITAL WILKENS & CATON AVE</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Hyaline Kern brain Dis</u> DUE TO, OR AS A CONSEQUENCE OF: <u>2 days</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?		22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>MAY 4,</u> 19 <u>71</u> to <u>MAY 6,</u> 19 <u>71</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>MAY 6,</u> 19 <u>71</u> and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.		
23A. SIGNATURE <u>S. Chittchang M.D.</u>		23B. DATE SIGNED <u>05608-71</u>		
23C. PHYSICIAN'S NAME (Type) <u>S. CHITTCHANG, M.D.</u>		23D. ADDRESS <u>BALTIMORE MD 21229</u> <u>ST AGNES HOSPITAL WILKENS & CATON AVE</u>		
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>May 7, 1971</u> 24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral Cem.</u> 24D. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>		
25A. DATE RECEIVED BY HEALTH DEPT. <u>MAY 10 1971</u>		25B. NAME OF REGISTRAR <u>John T. Stansbury</u> 25C. FUNERAL DIRECTOR <u>6411 Windsor Mill Rd.</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

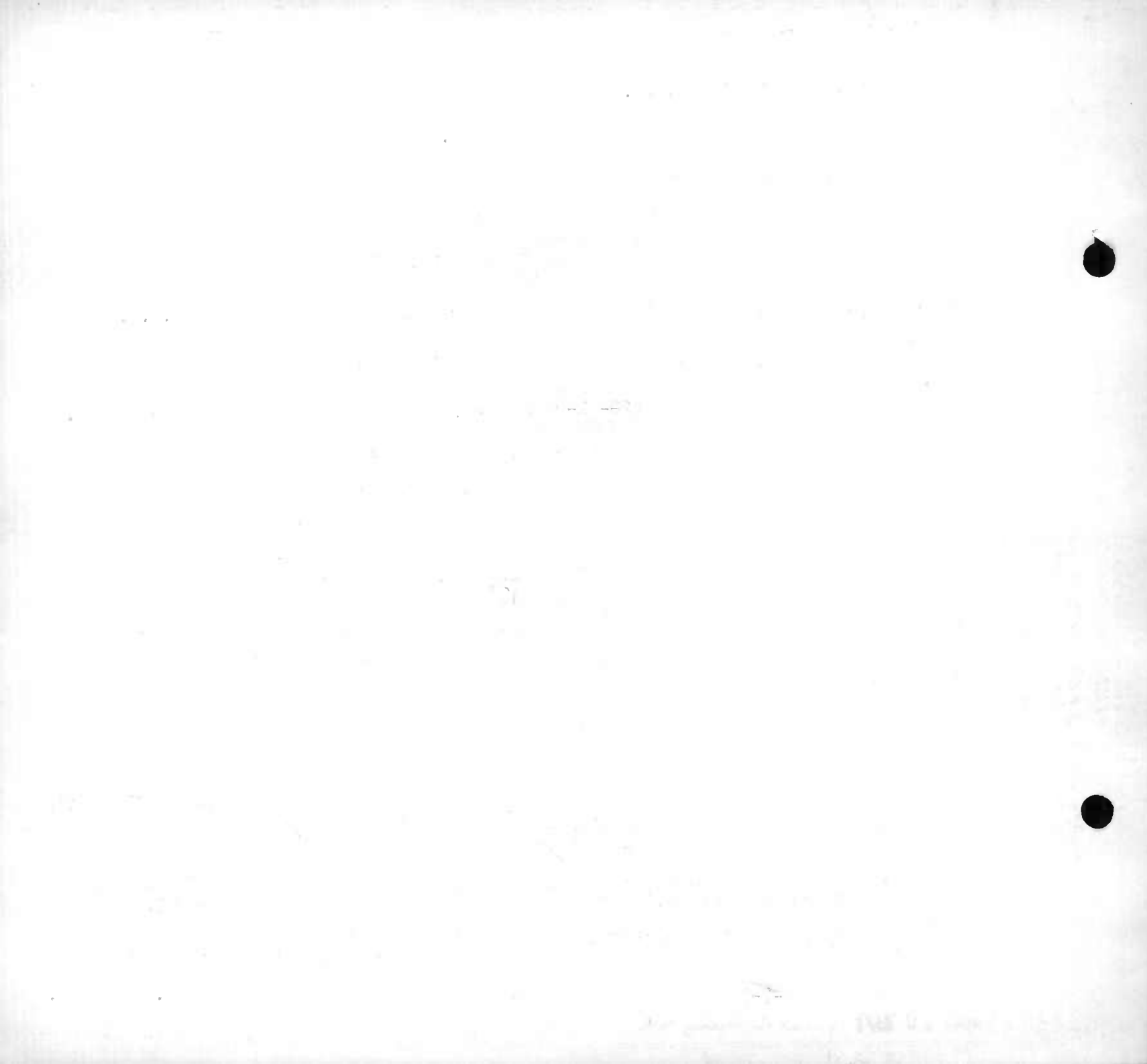
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>71 4462</u>
BIRTH NO. <u>M-260</u>		1. NAME OF DECEASED (Type or Print) <u>Ellen Perry Moser</u>		
2. DATE AND HOUR OF DEATH <u>May 5, 1971</u>		8:40 PM M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>US Public Health Service Hospital</u> <u>3100 Wyman Parkway</u>		A. STATE <u>W. Va.</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Eleanor</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>F</u>		6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>3/29/07</u>		9. AGE (In years last birthday) <u>64</u>		10. UNDER 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Va.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>C. Henry Perry</u>		
14. MOTHER'S MAIDEN NAME <u>Annie Groseclose</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>233-84-5635</u>		17. INFORMANT <u>Mr. Thomas E. Moser, 3326 Brandywine Ave. Records- US PHS Hospital, Balto, Md. Va.</u>		
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Pneumonia</u>		Days		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Acute myelocytic leukemia</u>		Years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Post necrotic cirrhosis</u>		Months		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>yes</u>
21D. TIME OF INJURY (APPROX) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>Dec 3</u> 19 <u>70</u> to <u>May 5</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>May 5</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (d/d/yy) view the body after death.				
23A. SIGNATURE <u>Frederick W. Bauer, MD</u>		23B. DATE SIGNED <u>5/6/71</u>		23C. PHYSICIAN'S NAME (Type) <u>Frederick W. Bauer, MD</u>
23D. ADDRESS <u>US PHS Hospital, Balto, Md.</u>		24. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		
24B. DATE <u>5-7-1971</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Crematory</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. ...</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 71 4463	
BIRTH NO. D-242 71 4463					
1. NAME OF DECEASED (Type or Print) <u>Nicholas Dashiells, Jr.</u>			2. DATE AND HOUR OF DEATH <u>5/5/71</u> <u>3:00 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>3418 Kentucky Avenue</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u>		
5. SEX <u>Male</u>			6. RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor & Builder</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		8. DATE OF BIRTH <u>July 27, 1877</u>
13. FATHER'S NAME <u>Nicholas Dashiells</u>			14. MOTHER'S MAIDEN NAME <u>Annie Schultz</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>220-01-6897A</u>		17. INFORMANT <u>Mrs. Alvina Dashiells 3418 Kentucky Ave.</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Arteriosclerotic heart disease</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <u>Benign Hypertensive Hypertrophy</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerosis</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Benign Hypertensive Hypertrophy</u> (C) DUE TO, OR AS A CONSEQUENCE OF: <u>Obstructive, ascending aortic atherosclerosis</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>5-7-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>July 17, 1970</u> to <u>May 5, 1971</u> that (I) (we) last saw the deceased alive on <u>May 4, 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Donald W. Mintzer</u>			23B. DATE SIGNED <u>5/5/71</u>		
23C. PHYSICIAN'S NAME (Type) <u>DONALD W. MINTZER</u>			23D. ADDRESS <u>3009 EVERGREEN AVE BALTO MD 21214</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-7-71</u>		24C. NAME of CEMETERY or CREMATORY <u>Druid Ridge Cemetery</u>	
24D. LOCATION <u>Pikesville Balto. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1971</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Lassahn Funeral Home 7401 Belair Road 21236</u>			

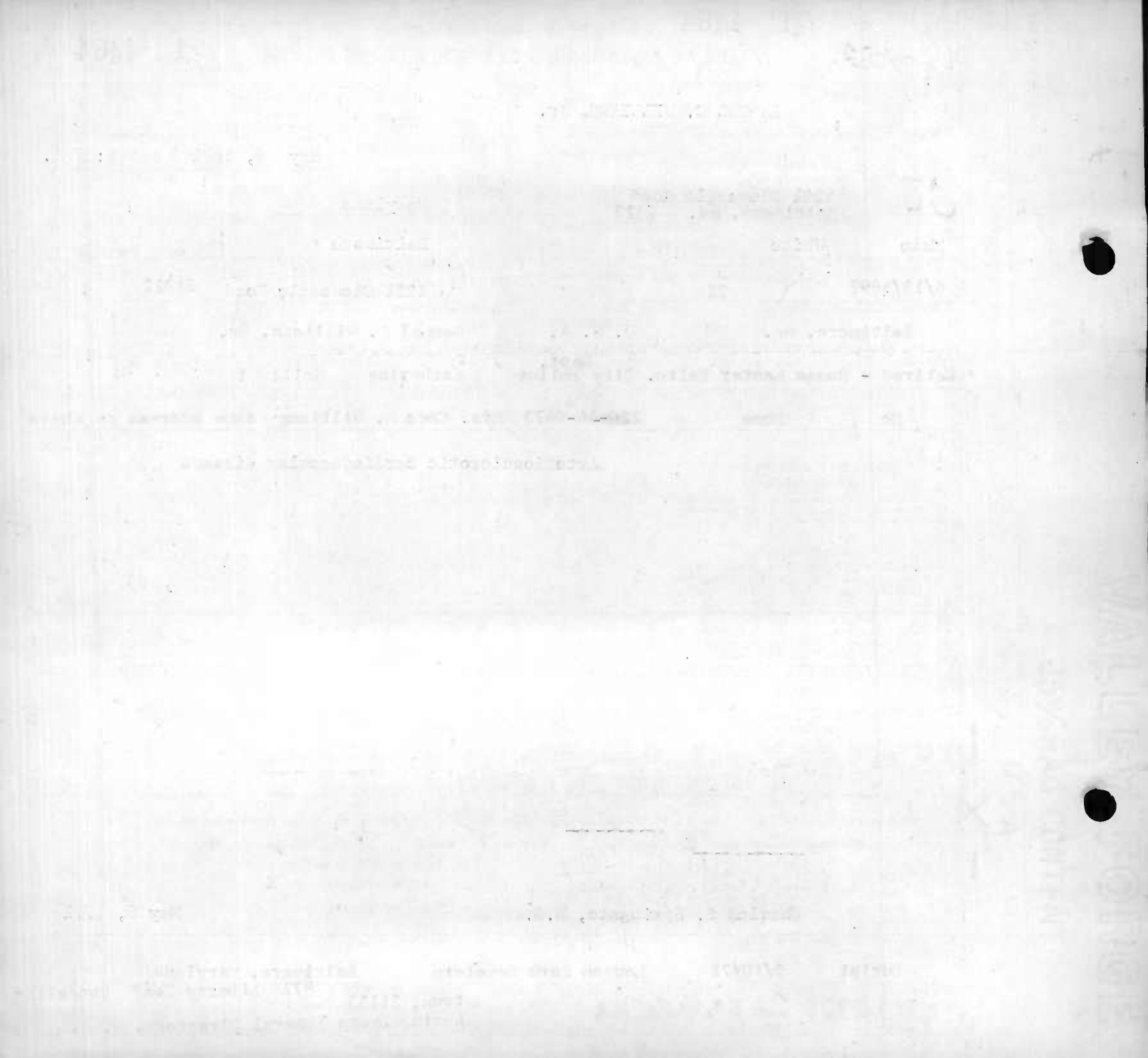


MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) SAMUEL C. WILLIAMS, Jr.		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1221 Gleneagle Road Baltimore, Md. 21212		3. DATE PRONOUNCED DEAD Month Day Year May 6, 1971 Hour 8:45 A.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY	
9. DATE OF BIRTH 6/13/1892		10. AGE (In years last birthday) 78	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Range Master Balto. City Police		14B. KIND OF BUSINESS OR INDUSTRY Dept.	
15. MOTHER'S MAIDEN NAME Katherine Grill		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 220-44-0473		18. INFORMANT Mrs. Cora M. Williams	
19. 4124 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		CAUSE OF DEATH Arteriosclerotic cardiovascular disease	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED May 6, 1971			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/10/71	
24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 10 1971		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR 8728 Liberty Road Randallstown, 21133		25D. NAME OF FUNERAL HOME Loring Byers Funeral Directors, P. A.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 4465

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LEE RICHARDSON

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Union Memorial Hospital (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

6. SEX

male

7. RACE

negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

Oct 6, 1933

10. AGE (In years
last birthday)

37

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1127 E. 20th St.

11. BIRTHPLACE (State or foreign country)

POTTSBURGH VA

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

Otis Richardson

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

Contractor

15. MOTHER'S MAIDEN NAME

Lou Carney

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Richardson Pottsville VA

19.

E 965 X

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Gunshot wound of chest
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

bar

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

2400 blk. Greenmount Ave.

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

5-7-71

p m.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Shot during argument.

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Isidore Mihalakis, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

5/8/71

24A. BURIAL CREMATION,
REMOVAL (Specify)

Cremation

24B. DATE

5/10/71

24C. NAME OF CEMETERY or CREMATORY

Family Plot

24D. LOCATION (City, town, or county) (State)

Pottsville VA

25A. DATE REC'D BY HEALTH DEPT.

MAY 10 1971

25B. NAME OF REGISTRAR

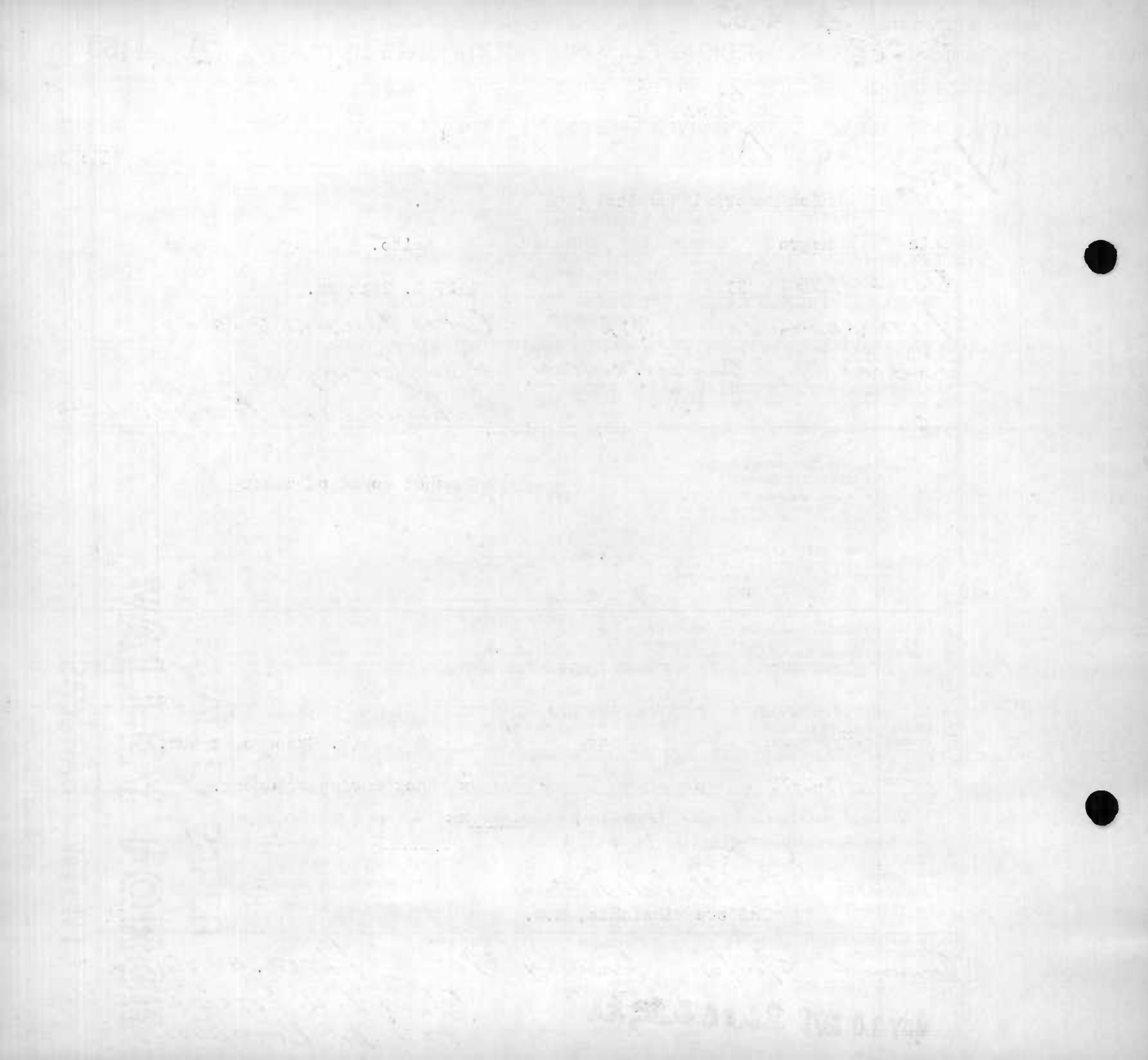
Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Blair L.H. Pottsville VA

ADDRESS

P.O. Box 6387 Green St



1. NAME OF DECEASED (Type or Print) COLES Henrietta Studivant		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3408 St. Ambrose Way		3. DATE PRONOUNCED DEAD Month Day Year Hour 5 7 71 6:47 a.	
6. SEX female		7. RACE colored	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH JAN 30-1941		10. AGE (In years last birthday) 30	
11. BIRTHPLACE (State or foreign country) LENOUR CO VA		12. CITIZEN OF USA	
13. FATHER'S NAME ROBERT COLES		14. MOTHER'S MAIDEN NAME LIZZIE JONES	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		16. KIND OF BUSINESS OR INDUSTRY HOSPITAL	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		18. SOCIAL SECURITY NO.	
19. CAUSE OF DEATH 5-71-8 I		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Fatty alteration of liver	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
22A. DATE OF OPERATION		22B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22C. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22D. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22E. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22F. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22G. HOW DID INJURY OCCUR?		22H. AUTOPSY? (Yes or No) yes	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 5/7/71			
24A. BURIAL CREMATION. REMOVAL (Specify) Removal		24B. DATE 5/8/71	
24C. NAME OF CEMETERY or CREMATORY Family Plot		24D. LOCATION (City, town, or county) (State) LENOUR CO VA	
25A. DATE REC'D BY HEALTH DEPT. MAY 10 1971		25B. NAME OF REGISTRAR Robert E. Fisher, R.D.	
25C. FUNERAL DIRECTOR J.P. Jones		25D. ADDRESS Hambridge Va	

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-650 71 4467		BALTIMORE CITY HEALTH DEPARTMENT		71 4467	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) MARIE MARION			2. DATE AND HOUR OF DEATH 5-5-71 7:15 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Lake Drive Nursing Home IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 2401 Eutan Place Baltimore, Md. 21217			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Baltimore		
5. SEX F			6. RACE N		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 3/19/08		
9. AGE (in years last birthday) 63			10. CITIZEN OF WHAT COUNTRY? U.S.A.		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME FRANK Roy			14. MOTHER'S MAIDEN NAME Kate Roy		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service] —			16. SOCIAL SECURITY NO. —		
17. INFORMANT Willie Marion			ADDRESS 709 N. Fulton Ave. Baltimore, Md.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.9 I CAUSE OF DEATH Cardiac arrest (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute myocardial infarction (B) DUE TO, OR AS A CONSEQUENCE OF: ASHD + ASVD + Diabetes mellitus (C) ASHD + ASVD + Diabetes mellitus			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. DATE OF OPERATION 5-8-71			20. AUTOPSY? (Yes or No) —		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) —		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR? —		
22. I certify that (I) (this hospital) attended the deceased from 4-8-71 to 5-5-71 that (I) (we) last saw the deceased alive on 4-23-71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. Albuerne			23B. DATE SIGNED 5-5-71		
23C. PHYSICIAN'S NAME (Type) MARCELINO F. ALBUERNE MD.			23D. ADDRESS 7935 RIVERS PARK JEN BUNNIE MD 21061		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-8-71		24C. NAME OF CEMETERY OR CREMATORY St. Ambrose Ceme	
24D. LOCATION (City, town, or county) Baltimore, Md		24E. STATE Md		24F. COUNTY Baltimore	
25A. DATE REC'D BY HEALTH DEPT. MAY 10 1971		25B. NAME OF REGISTRAR John F. ...		25C. FUNERAL DIRECTOR Moetor + Dyett F. H. 1701-Lawson St	



1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
JEROME F. WRIGHT		Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> May 6, 1971 M.		Month Day Year May 6, 1971 9:09 A. M.		BON SECOURS HOSPITAL (DOA)		A. STATE B. COUNTY Maryland	
6. SEX Male		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH Dec 2, 1940		10. AGE (In years lost birthday) 30		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME William Wright	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Mary E. Williams		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 216-36-4120	
18. INFORMANT Julene Wright		ADDRESS 2629 Edmondson Avenue		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-10-71		24C. NAME of CEMETERY or CREMATORY Pine Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Annapolis, Md.	
25A. DATE REC'D BY HEALTH DEPT. MAY 10 1971		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Morton & Dyett F. H.		ADDRESS 1701 Laurens Street			

210-30-1122

WILLIAM F. (D) R.

the last century

1-1-7

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 4469		REG. NO.	
CERTIFICATE OF DEATH							
BIRTH NO. 7-460		71 4469		2. DATE AND HOUR OF DEATH 5-6-71 1-20AM		M.	
1. NAME OF DECEASED (Type or Print) CLARA FULLER				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Provident Hospital, Inc. 2600 Liberty Heights Avenue Baltimore, Maryland 21215				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland			
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3715 Reistertown Road 1512			
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-3-95	9. AGE (In years last birthday) 75	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY U.S. A.	
13. FATHER'S NAME Harry White				14. MOTHER'S MAIDEN NAME Mary White			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-18-9866		17. INFORMANT Mrs. Francis Steiff (Daughter)		ADDRESS Same	
18. 410.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) ACUTE MASSIVE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF: (C) ARTERIOSCLEROSIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTERIOSCLEROSIS OBLITERANS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 DAYS			
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). ARTERIOSCLEROSIS OBLITERANS							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5-3-71 19 to 5-6-71 19 that (I) (we) last saw the deceased alive on 5-6-71 19 and that (in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Y. K. RAMAIAH, M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5-6-71	
23C. PHYSICIAN'S NAME (Type) Y. K. RAMAIAH, M.D.				23D. ADDRESS PROVIDENT HOSPITAL, BALTIMORE			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-10-71		24C. NAME of CEMETERY or CREMATORY Western Star Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland MD	
25A. DATE RECEIVED BY HEALTH DEPT. MAY 10 1971		25B. NAME OF REGISTRAR Y. K. RAMAIAH, M.D.		25C. FUNERAL DIRECTOR Morton & Dyett F. H.		ADDRESS 1701 Laurens Street	

10-2-17

17-1-2

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

S-35071

4470

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 71 4470

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ROBERT G. SUTTON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1835 Division St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 5 7 1971 4:50 p.m.	
6. SEX male		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH Jan 10, 1916		10. AGE (In years lost birthday) 55	
11. BIRTHPLACE (State or foreign country) Norththumberland Co., Va.		12. CITIZEN OF U. S. A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker		14B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel	
15. MOTHER'S MAIDEN NAME Carrie H. Sutton		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. 227-12-9481		18. INFORMANT Mrs. Barbara Yerby	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. DATE OF OPERATION		21. AUTOPSY? (Yes or No) NO	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Isidore Mihalakis, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 5/8/71			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-12-71	
24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 10 1971		25B. NAME OF REGISTRAR Robert E. Yerby, M.D.	
25C. FUNERAL DIRECTOR Morton & Dyett F. H.		25D. ADDRESS 1701 Laurens St.	

1531-3170

5. *Robertson, James*

10/17/2018 10:17:28

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-525 71 4471				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 71 4471	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Johnson, Lena</u>				2. DATE AND HOUR OF DEATH <u>May 6 1971 11:40 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u>				E. STREET AND NUMBER <u>1718 Presbury St.</u>		1502			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>08-05-06</u>	9. AGE (In years last birthday) <u>64</u>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Johnson, (husband)</u>		ADDRESS <u>Same as above</u>		
18. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Myocardial Infarction.</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ASCVD</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>(cardiogenic shock)</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>?</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 h.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR					
22. I certify that (I) (this hospital) attended the deceased from <u>Apr. 23</u> 19 <u>71</u> to <u>May 6</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>May 6</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Tobru OHE MD</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>May 6, 1971</u>			
23C. PHYSICIAN'S NAME (Type) <u>Tobru OHE MD</u>				23D. ADDRESS <u>Union Memorial Hospital</u>					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>5-10-71</u>		24C. NAME of CEMETERY or CREMATORY <u>Arbutus Mem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1971</u>		25B. NAME OF REGISTRAR <u>Robert E. Tabor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Robert H. Dettl</u>		ADDRESS <u>1701-1705</u>			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 4472</u>	
BIRTH NO. <u>U-240</u> <u>71 4472</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>LOUIS UZZELL (Lewis)</u>			2. DATE AND HOUR OF DEATH <u>5/5/71</u> <u>7:30 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>md.</u> B. COUNTY <u>Baltimore</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Balton Hill Nursing Home</u> <u>1400 John St - Balto. Md.</u>			C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <u>21 W. Fayette St.</u>			F. INSIDE CITY LIMITS? <u>401</u>		
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/1/10</u>	9. AGE (in years last birthday) <u>60</u>	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Abraham Uzzell</u>			14. MOTHER'S MAIDEN NAME <u>Pianna Uzzell</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>237-28-0325</u>		
17. INFORMANT <u>Admission Record</u>			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>obstructive uropathy</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Benign Prostatic Hypertrophy</u>			DUE TO, OR AS A CONSEQUENCE OF: <u>1 yr.</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Non functioning left kidney</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>		
19A. DATE OF OPERATION <u>5-5-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4-30-</u> <u>1971</u> to <u>5-5-</u> <u>1971</u> that (I) (we) last saw the deceased alive on <u>4-30-</u> <u>1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>E. Ellsworth Cook M.D.</u>			23B. DATE SIGNED <u>5-5-71</u>		
23C. PHYSICIAN'S NAME (Type) <u>E. Ellsworth Cook M.D.</u>			23D. ADDRESS <u>2431 Maryland Ave. Balto Md</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/9/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>O'Mill Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Wayne Co., N. C.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1971</u>			
25B. NAME OF REGISTRAR <u>J. E. Rader, M.D.</u>		25C. FUNERAL DIRECTOR <u>Morton & Dyett Funeral Home Balto Md 21217</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>H-645 71 4473</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 71 4473</p>	
<p>BIRTH NO. _____</p>		<p>1. NAME OF DECEASED (Type or Print) Hirleman, Charles</p>	
<p>2. DATE AND HOUR OF DEATH 5-5-71 8:50 AM</p>		<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Bolton Hill Nursing Home</p>	
<p>4. USUAL RESIDENCE (Where deceased lived; If institution; residence before admission) A. STATE Md. B. COUNTY Balto.</p>		<p>5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Bolton Hill Nursing Home</p>	
<p>6. CITY OR TOWN Balto.</p>		<p>7. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>8. STREET AND NUMBER 19 Manor Ave. Balto. 5300</p>		<p>9. SEX M 10. RACE W 11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	
<p>12. DATE OF BIRTH 5-17-78</p>		<p>13. AGE (In years last birthday) 92-93</p>	
<p>14. BIRTHPLACE (State or foreign country) Pa.</p>		<p>15. CITIZEN OF WHAT COUNTRY? USA</p>	
<p>16. FATHER'S NAME Hirleman, Edward</p>		<p>17. MOTHER'S MAIDEN NAME Sidney</p>	
<p>18. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p>19. SOCIAL SECURITY NO. 187-10-4338</p>	
<p>20. INFORMANT Admission Record</p>		<p>21. ADDRESS</p>	
<p>22. CAUSE OF DEATH Pneumonitis</p>		<p>23. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days</p>	
<p>24. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p>		<p>25. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>	
<p>26. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Generalized arteriosclerosis</p>		<p>27. SEVERAL YRS. Several yrs.</p>	
<p>28. DATE OF OPERATION 0</p>		<p>29. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>30. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>31. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>32. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>		<p>33. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	
<p>34. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>35. HOW DID INJURY OCCUR?</p>	
<p>36. I certify that (I) (this hospital) attended the deceased from 12-22-1966 to 5-5-1971 that (I) (we) last saw the deceased alive on 5-2-1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>37. SIGNATURE E. Ellsworth Cook MD</p>		<p>38. DATE SIGNED 5-5-71</p>	
<p>39. PHYSICIAN'S NAME (Type) E. Ellsworth Cook MD</p>		<p>40. ADDRESS 2431 Md. Ave. Balto. Md 21218</p>	
<p>41. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>42. DATE 5-8-1971</p>	
<p>43. NAME OF CEMETERY OR CREMATORY Laureldale Cemetery</p>		<p>44. LOCATION (City, town, or county) (State) Laureldale Pennsylvania</p>	
<p>45. DATE REC'D BY HEALTH DEPT. MAY 10 1971</p>		<p>46. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Rd. Balto. Md</p>	

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
W. Dalley Farrior		Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.		Month Day Year Hour 5 7 71 4:35 a.m.		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2319 Druid Hill Ave.		A. STATE Maryland B. COUNTY	
6. SEX male		7. RACE colored		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH 9-3-1886		10. AGE (In years last birthday) 86	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Henry Farrior		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter		15. MOTHER'S MAIDEN NAME Lsabelle Robinson	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes		17. SOCIAL SECURITY NO. Spanish American 212-18-8280		18. INFORMANT Mrs. Pearl Farrior		19. CAUSE OF DEATH 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-11-1971		24C. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland		25A. DATE REC'D BY HEALTH DEPT. MAY 10 1971	
25B. NAME OF REGISTRAR Robert E. Farrior, M.D.		25C. FUNERAL DIRECTOR NUTTER FUNERAL HOME		25D. ADDRESS 3035 W. NORTH AVENUE		25E. DATE SIGNED 5/7/71		25F. NAME OF EXAMINER Werner U. Spitz, M.D.	

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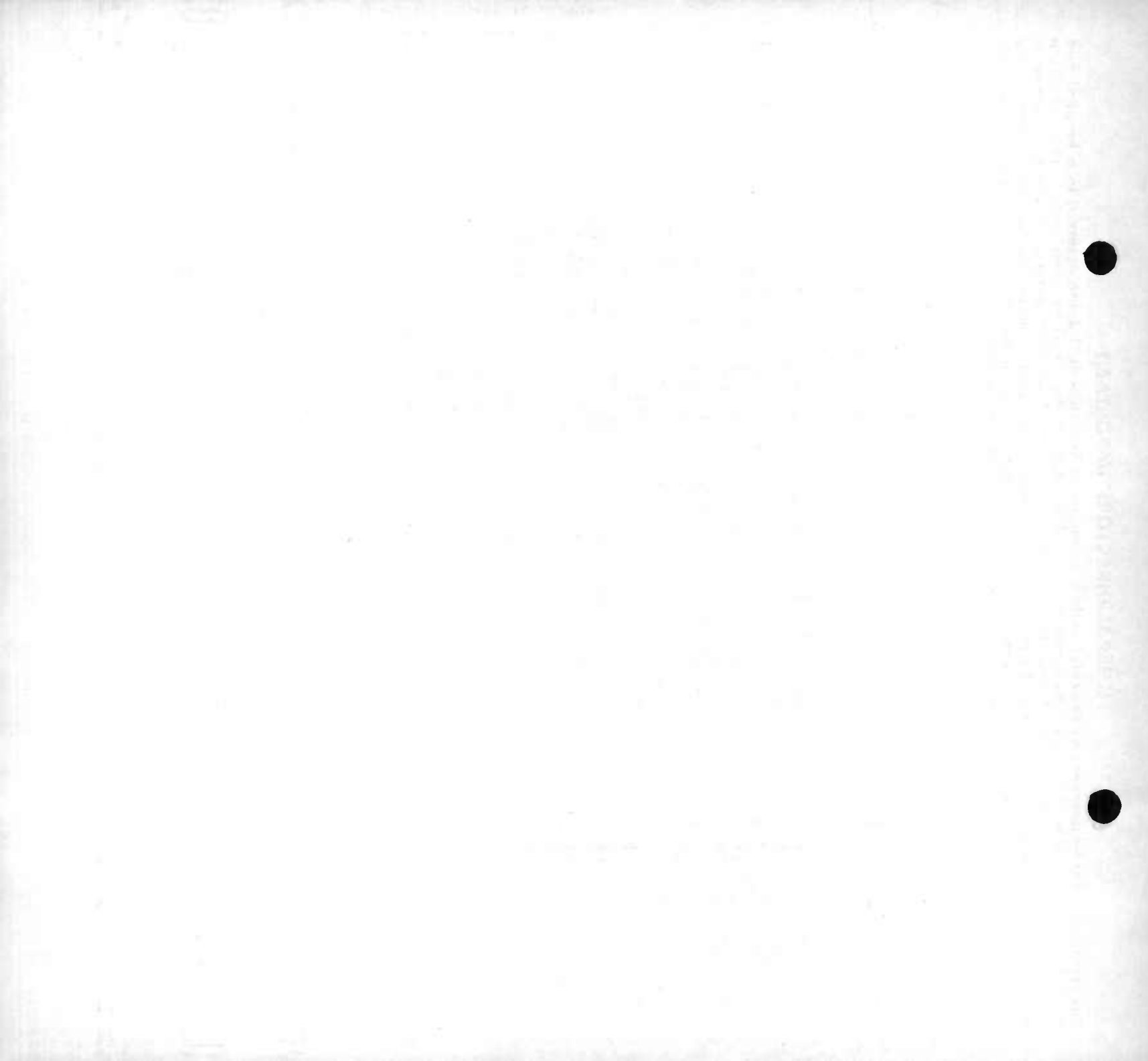
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

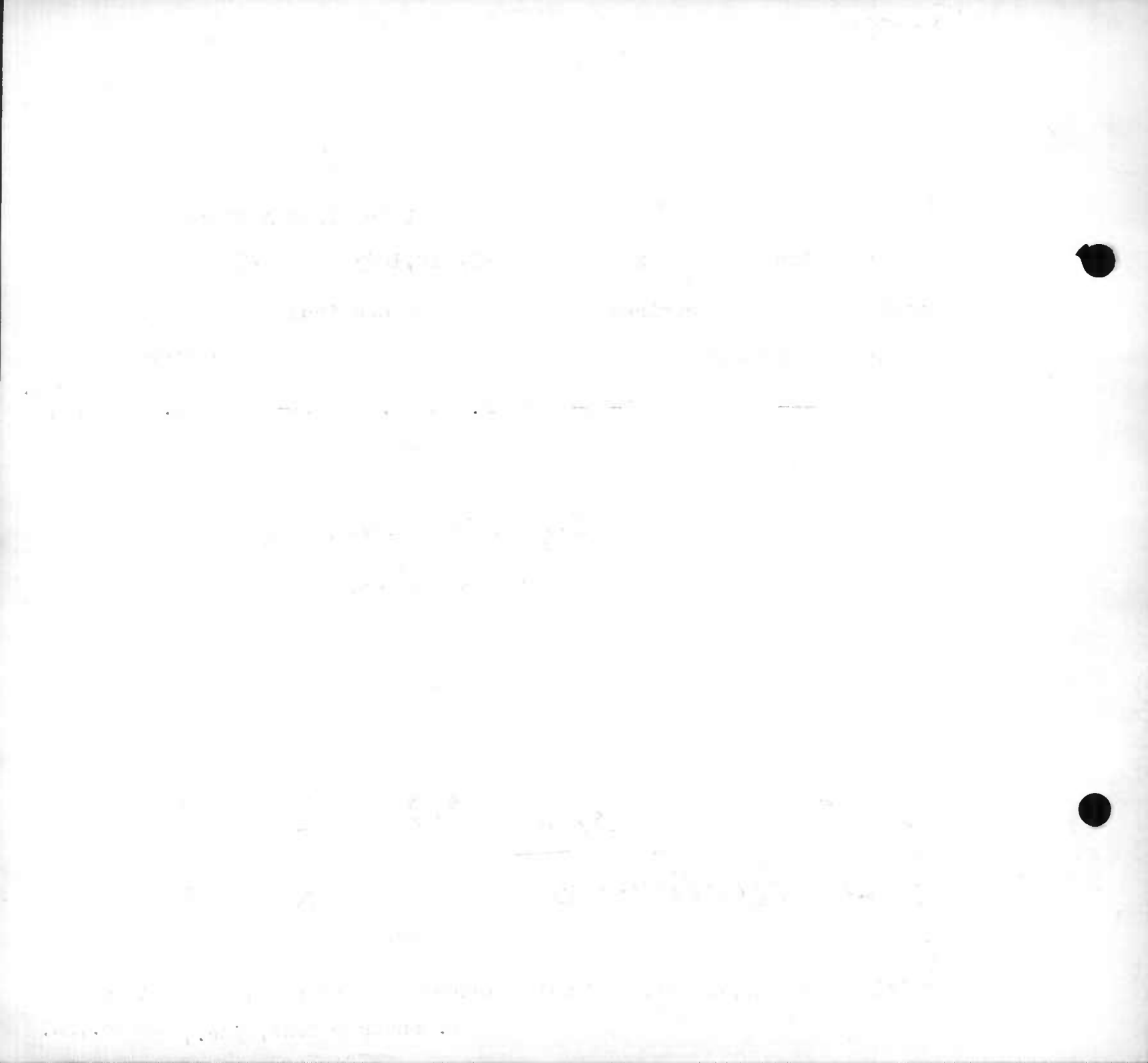
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 4475</u>
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>Charles W. Jarvis</u>		2. DATE AND HOUR OF DEATH <u>May 3, 1971</u> <u>11 p.m.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>39 Provident Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2304 Edmondson Avenue</u> <u>1605</u>		
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-13-1900</u>	9. AGE (In years last birthday) <u>70</u> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tractor Operator</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>B & O Railroad</u>		
11. BIRTHPLACE (State or foreign country) <u>Matthew Co. Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Scott Jarvis</u>		14. MOTHER'S MAIDEN NAME <u>Emma ?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-09-6617</u>		
17. INFORMANT <u>Mrs. Elsie S. Jarvis</u>		ADDRESS <u>2304 Edmondson Av</u>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>5-3-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>BPH</u>		20A. AUTOPSY? (Yes or No) <u>No</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>3/5</u> <u>1971</u> to <u>5/3</u> <u>1971</u> that (I) (we) last saw the deceased alive on <u>5/3</u> <u>1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Ralph M. Howard</u> DEGREE <u>M. D.</u>				23B. DATE SIGNED <u>5-4-71</u>
23C. PHYSICIAN'S NAME (Type) <u>Ralph M. Howard</u>		23D. ADDRESS <u>North Avenue & Eutaw Place</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5-8-1971</u>		24C. NAME of CEMETERY or CREMATORY <u>Family Lot</u>
24D. LOCATION (City, town, or county) (State) <u>Matthew Co. Va.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1971</u>		
25B. NAME OF REGISTRAR <u>Ralph M. Howard</u>		25C. FUNERAL DIRECTOR ADDRESS <u>NUTTER FUNERAL HOME 3035 W. NORTH AV</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4476	
B-524 71 4476					
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) BERNADETTE ROSE SENECA			2. DATE AND HOUR OF DEATH 5-6-71 13:50 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) B. Mercy Hospital			A. STATE Maryland		
			C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 1026 Hillman Street 1001			F. DATE OF BIRTH July 14, 1893		
			G. AGE (in years last birthday) 77		
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cook		10B. KIND OF BUSINESS OR INDUSTRY retired		11. BIRTHPLACE (State or foreign country) Connecticut	
13. FATHER'S NAME Edmond Garnier		14. MOTHER'S MAIDEN NAME JOSEPHINE Fortier			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 041-05-3863		17. INFORMANT Mr. John E. Senecal-Brenn Dr. Brooklyn, Conn.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) C.V.A.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Aspiration pneumonia		
			(B) DUE TO, OR AS A CONSEQUENCE OF: A.S.C.V.D.		
			(C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 5/6/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 5/3 19 71 to 5/6/71 19 71 that (we) last saw the deceased alive on 5/6 19 71 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED 5/6/71	
23C. PHYSICIAN'S NAME (Type) [Signature]				23D. ADDRESS Mercy Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE May 10, 71		24C. NAME of CEMETERY or CREMATORY Sacred Heart Cemetery	
24D. LOCATION (City, town, or county) (State) Wauregan, Connecticut		25A. DATE REC'D BY HEALTH DEPT. MAY 10 1971			
25B. NAME of REGISTRAR Robert E. Sander, M.D.		25C. FUNERAL DIRECTOR H. Sander & Sons, Inc., Balto., Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 4477</u>	
BIRTH NO. <u>H-534</u>		71 4477		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Huntley, Hattie</u>			2. DATE AND HOUR OF DEATH <u>5/8/71</u> <u>9²⁰</u> <u>A</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Mc Ken Hosp</u>			A. STATE <u>MD</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>B'mre</u>			C. CITY OR TOWN <u>B'mre</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>F</u>			6. RACE <u>N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
8. DATE OF BIRTH <u>6/15/12</u>			9. AGE (in years last birthday) <u>38</u>		10. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Thomas Henry</u>		
14. MOTHER'S MAIDEN NAME <u>Hattie</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO.			17. INFORMANT <u>Conce Huntley</u>		
18. <u>1899 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) <u>Metastatic Cancer Uterus</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 Y known</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Metastatic Cancer Uterus</u>		
(B) DUE TO, OR AS A CONSEQUENCE OF:			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>1970</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>4/20</u> 19 <u>71</u> to <u>5/8</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>5/8/71</u> 19 <u>71</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>James Henry M.D.</u>				23B. DATE SIGNED <u>5/8/71</u>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>5-10-71</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Mem Park Arbutus</u>	
24D. LOCATION (City, town, or county) (Street)		24E. NAME OF REGISTRAR <u>Robert E. ...</u>		24F. FUNERAL DIRECTOR <u>James H. ...</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1971</u>		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	



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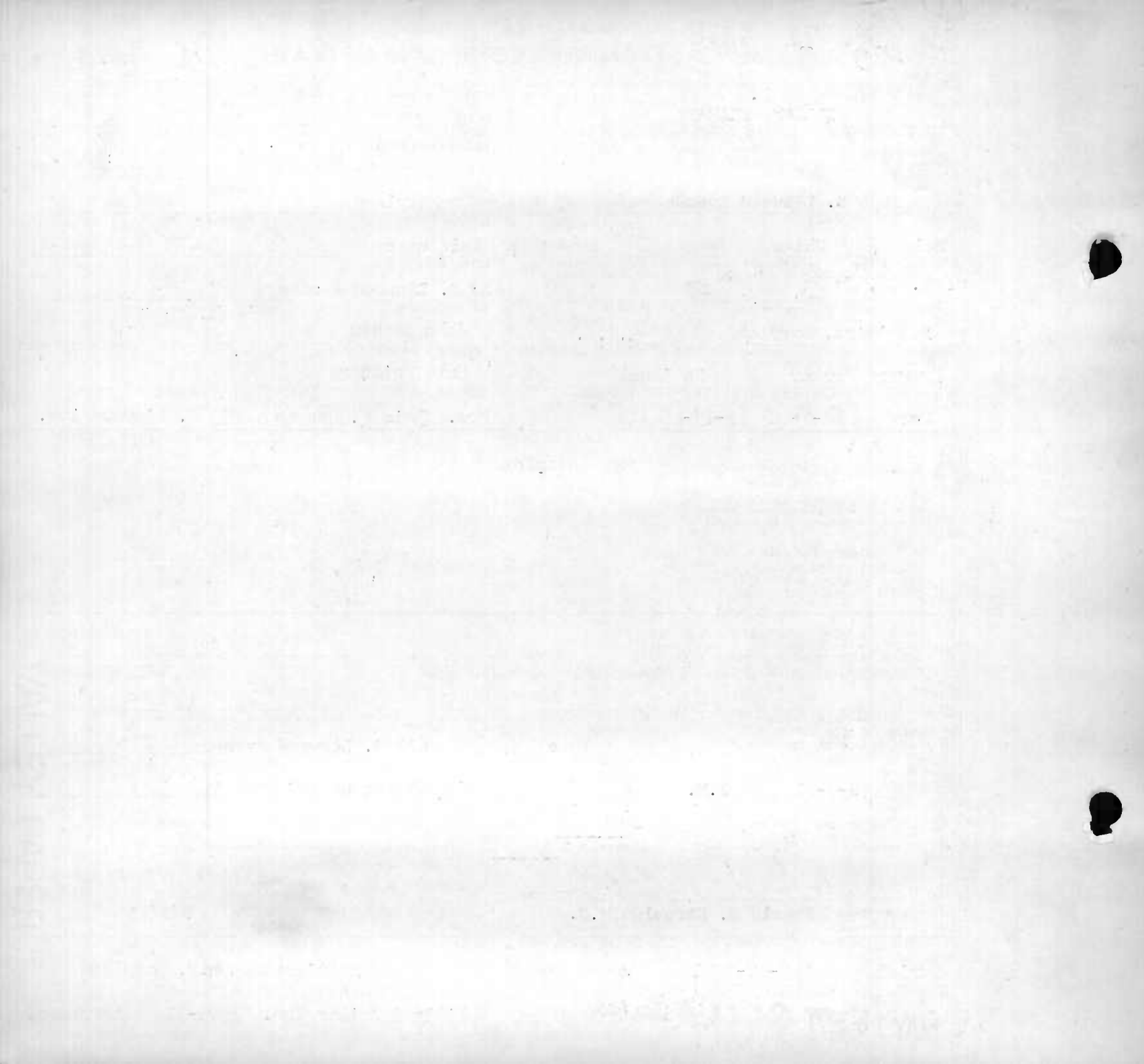
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 4478

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM REAGAN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 633 S. Linwood Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour May 8, 1971 4:15 P. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Oct. 23, 1917		10. AGE (In years last birthday) 53	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brewery Worker		14B. KIND OF BUSINESS OR INDUSTRY National	
15. MOTHER'S MAIDEN NAME Kate Weisner		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes 10-7-42 12-15-45	
17. SOCIAL SECURITY NO.		18. INFORMANT Mrs. Elsie M. Reagan	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hanging		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
22. (C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 633 S. Linwood Avenue 1-02			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 5-8-71 P.M.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Subject hanged himself			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 5/9/71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-12-1971	
24C. NAME of CEMETERY or CREMATORY Sacred Heart		24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland	
25A. DATE REC'D BY HEALTH DEPT. MAY 10 1971		25B. NAME OF REGISTRAR John E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Lilly & Zeiler Inc.		ADDRESS 1901-07 Eastern Ave.	

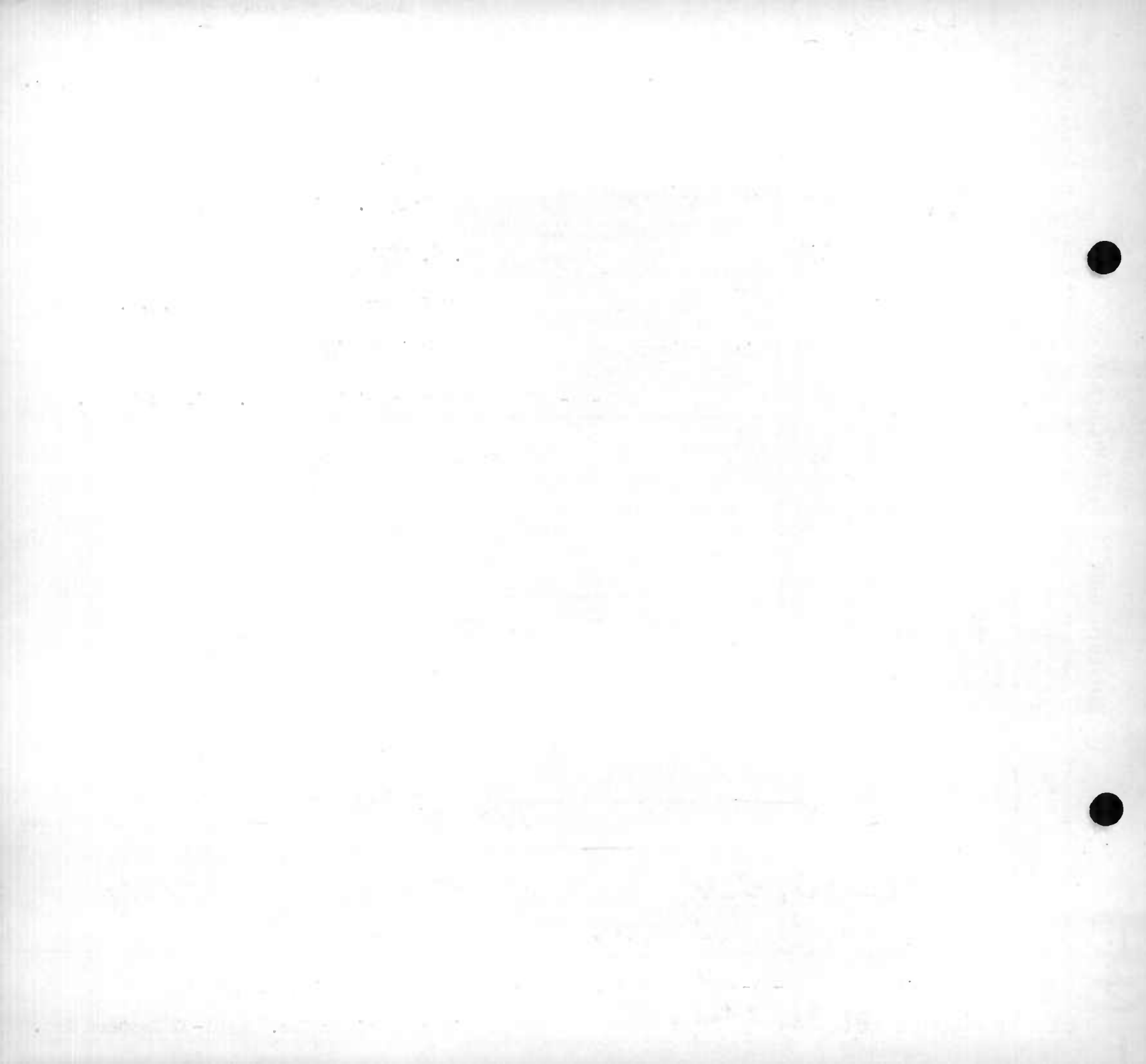
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4479	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) FLORENCE B. PAPCIAK		2. DATE AND HOUR OF DEATH May 9, 1971 7 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Gould Convalesarium			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1827 E. Fairmount Avenue 604		
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 6, 1897	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) New Jersey	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Augustine Calhoun		
14. MOTHER'S MAIDEN NAME Prudence Nickerson			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 220-12-1879			17. INFORMANT Andrew Papciak ADDRESS 1827 E. Fairmount Ave.		
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Acute Cerebrovascular Accident (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <div style="text-align: center;">II</div> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Prior CVA; Diabetes; Chronic Brain Syndrome </div> <div style="width: 15%; text-align: center;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days years </div> </div>					

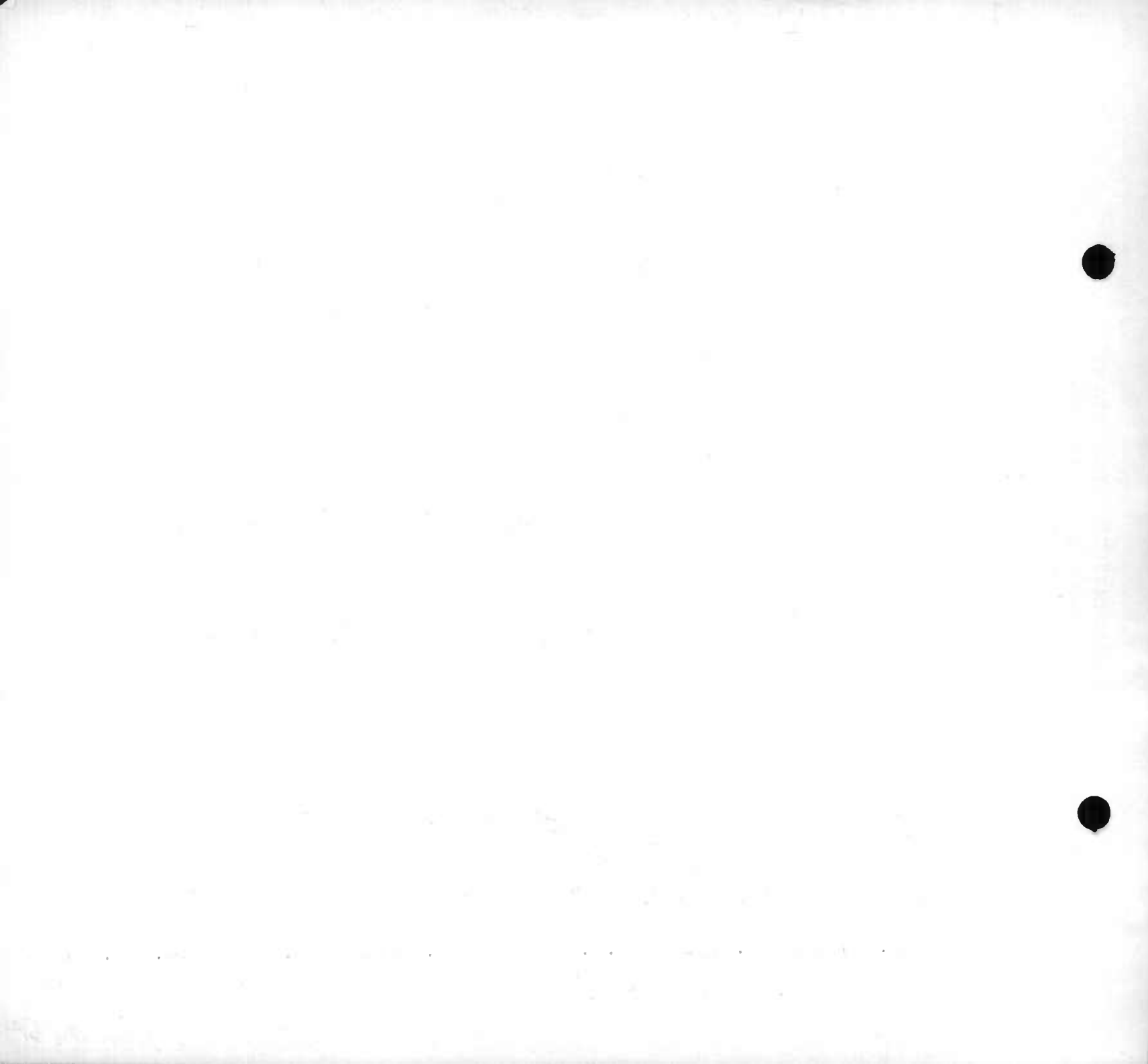


BIRTH NO.		1. NAME OF DECEASED (Type or Print) Lee Wardell		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1230 N. Caroline St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 5 4 71 7:35 a. M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1001	
6. SEX male	7. RACE colored	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 12-10-09		10. AGE (In years lost birthday) 32		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?		E. STREET AND NUMBER 1230 N. Caroline St.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME Lee Wardell	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		15. MOTHER'S MAIDEN NAME Carrie M. Anderson	
19. 41212 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic and hypertensive cardiovascular disease		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		18. INFORMANT Carrie Wardell, 1014 E. Preston St ADDRESS	
19. 41212 II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: [Signature] M.D. DATE SIGNED: 5/4/71 EXAMINER'S NAME (Type): Werner U. Spitz, M.D. Deputy Chief Medical Examiner CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-8-71		24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.	
25A. DATE REC'D BY HEALTH DEPT. MAY 10 1971		25B. NAME OF REGISTRAR John E. [Signature]		25C. FUNERAL DIRECTOR Rayner Sanders	
				24D. LOCATION (City, town, or county) (State) D. A. Co. Md 217 E. Preston St	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-525 71 4481		BALTIMORE CITY HEALTH DEPARTMENT		71 4481	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <i>Augustine Johnson</i>			2. DATE AND HOUR OF DEATH <i>5/5/71</i> <i>2:00 P.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD.</i> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>George Washington N/H</i> <i>607 PENNA. AVENUE</i>			C. CITY OR TOWN <i>BALTO. MD.</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <i>F</i> 6. RACE <i>NEGRO</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <i>11-21-16</i>		9. AGE (In years last birthday) <i>54</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSE WIFE</i>			11. BIRTHPLACE (State or foreign country) <i>BALTO. MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>John W. Johnson</i>			14. MOTHER'S MAIDEN NAME <i>Matilda Horacie</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NONE</i>			16. SOCIAL SECURITY NO. <i>NONE</i>		17. INFORMANT ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>CARCINOMA CERVIX</i>			CAUSE OF DEATH <i>CARCINOMA CERVIX</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1968</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>CEREBRAL APOPLEXY</i>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>CEREBRAL APOPLEXY</i>		<i>1961</i>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Diabetes mellitus</i>			(B) DUE TO, OR AS A CONSEQUENCE OF: <i>HASCU</i>		<i>1950</i>
19A. DATE OF OPERATION <i>180X+1250.9</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (1) (this hospital) attended the deceased from <i>4-26-71</i> to <i>5-5-71</i> that (1) (we) last saw the deceased alive on <i>5-3-71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Dr. Richard F. Tyson, M.D.</i>			23B. DATE SIGNED <i>5-5-71</i>		23C. PHYSICIAN'S NAME (Type) <i>Dr. Richard F. Tyson M.D.</i>
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>			24B. DATE <i>5/10/71</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Calvary Cem</i>
24D. LOCATION (City, town, or county) (State) <i>BALTO. MD.</i>			24E. FUNERAL DIRECTOR <i>Rayner Sanders</i>		24F. ADDRESS <i>217 E. Preston St</i>
25A. DATE RECEIVED BY HEALTH DEPT. <i>MAY 10 1971</i>					



1

S-315⁷¹ 4482 BALTIMORE CITY HEALTH DEPARTMENT
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 4482

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARY STEVINSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2712 Elisnor Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour 5 2 1971 10:30 p.m.	
6. SEX female		7. RACE negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH Mar-6-80		10. AGE (In years lost birthday) 91	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME Mary Brown	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		18. SOCIAL SECURITY NO.	
19. INFORMANT Mabel Holland		ADDRESS 2712 Elisnor Ave.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 5/3/71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-7-71	
24C. NAME OF CEMETERY or CREMATORY Mt Calvary Cem. A.D. Co		24D. LOCATION (City, town, or county) (State) Md	
25A. DATE REC'D BY HEALTH DEPT. MAY 10 1971		25B. NAME OF REGISTRAR Robert L. Taylor, M.D.	
25C. FUNERAL DIRECTOR Rayner Sanders		ADDRESS 217 E Preston	

VS 151-REV. 1/1/68

WILLIAM W. FOLGER

NEW YORK

1874

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 71 4483	
W-452 71 4483		BIRTH NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Estelle Williams		5-9-71		8:45 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224		Maryland		Baltimore	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	
Female		Negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
David Bedford		Annie Williams		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No				4940 Eastern Avenue BCH-Records Baltimore, Maryland 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Mediastinal Carcinoma 2445	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		Adenocarcinoma of colon	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (All stating the UNDERLYING CONDITION last.)		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from		19 71 to		19 71	
that (I) (we) last saw the deceased alive on		19 71 and that (in my) (our) opinion death occurred on the date		and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE		23B. DATE SIGNED			
Ronald Blum MD.		5/9/71			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Ronald Blum MD.		BCH- 4940 Eastern Avenue Baltimore, Md. 21224			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		5-13-71		St. Stevens Cal	
25A. DATA REC'D BY DEATH OFFICE		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
MAY 10 1971		John E. Taylor, Jr.		Wilson 1000 Crumby Ln	



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W-452 71 4484

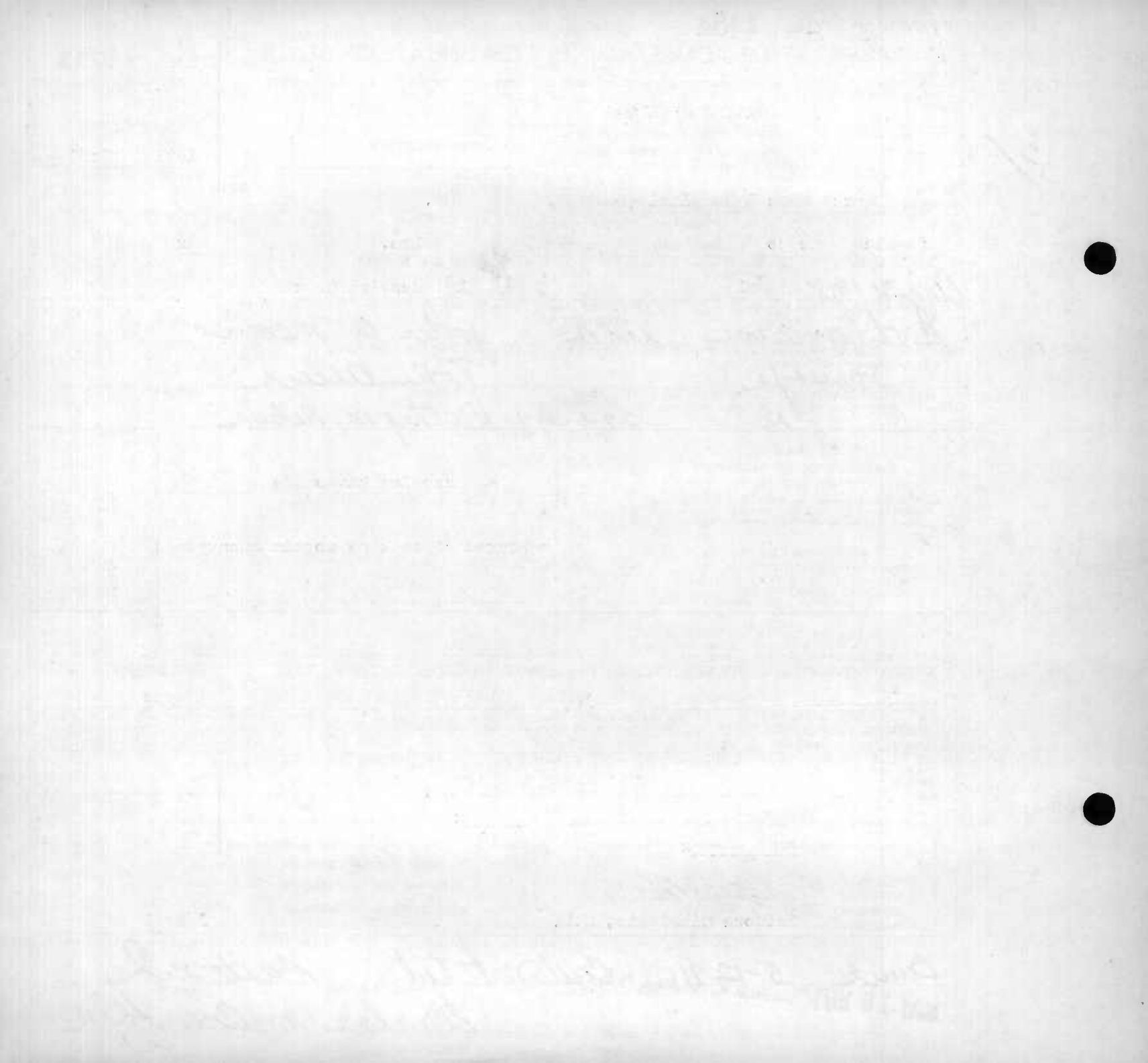
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 4484

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LORAIN WILLIAMS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Church Home & Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour 5 7 1971 3:30 p.m.	
6. SEX female		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY	
7. RACE negro		C. CITY OR TOWN Balto.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH Aug 31 1918		E. STREET AND NUMBER 287 Herring Court 301	
10. AGE (In years last birthday) 52		11. BIRTHPLACE (State or foreign country) North Carolina	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John A. Means	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		15. MOTHER'S MAIDEN NAME Ronie Allen	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 219-16-3897	
18. INFORMANT Dorothy M. Nelson		ADDRESS	
19. 441.0		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE cardiac tamponade DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) ruptured dissecting aortic aneurysm DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Isidore Mihalakis, M.D.		DATE SIGNED 5/8/71	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-12-71	
24C. NAME OF CEMETERY or CREMATORY Baltimore Nat. Cem.		24D. LOCATION (City, town, or county) (State) Balto Md	
25A. DATE RECEIVED BY HEALTH DEPT. MAY 10 1971		25B. NAME OF REGISTRAR Constance von Brantley	
25C. FUNERAL DIRECTOR Constance von Brantley		ADDRESS	

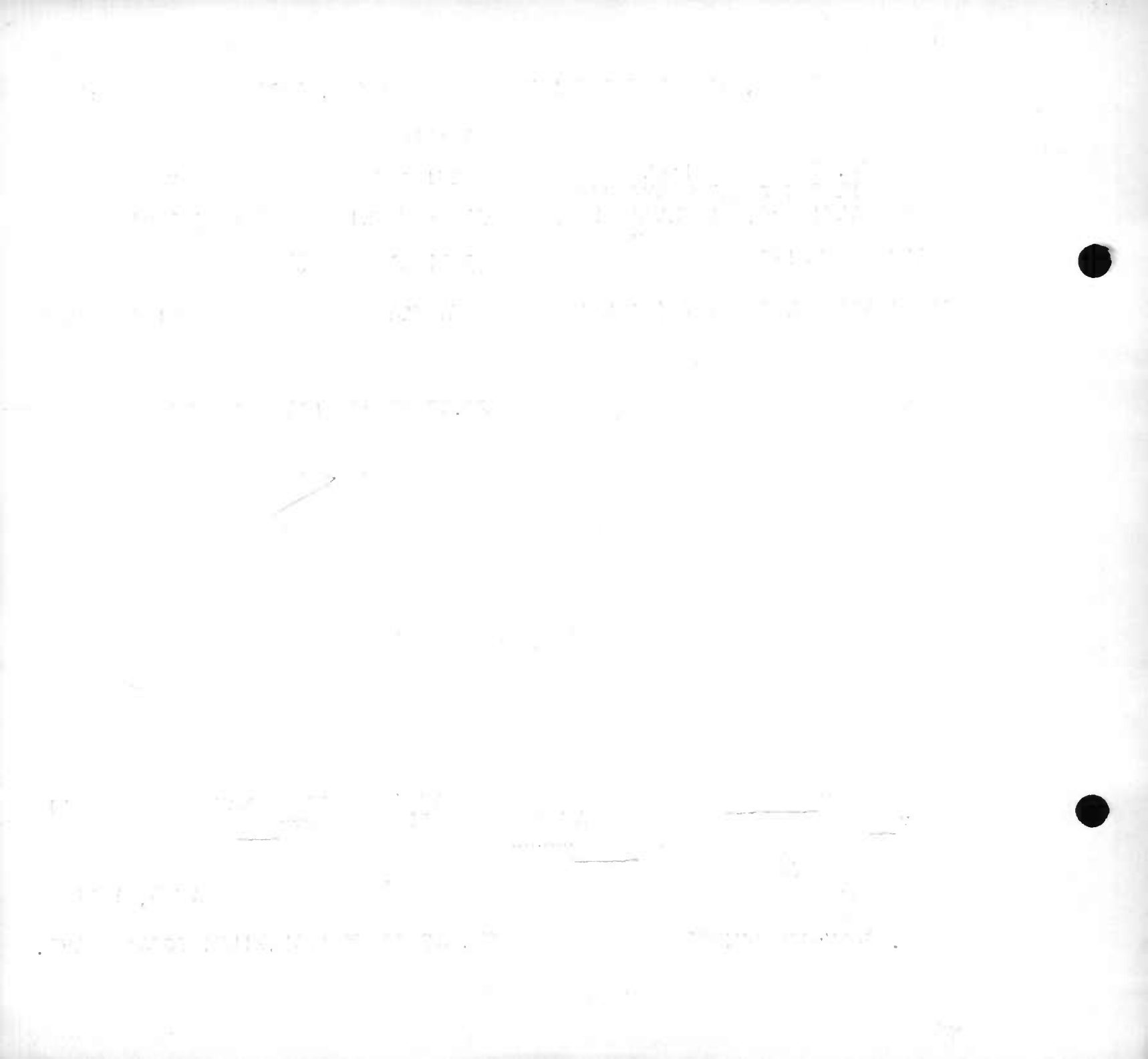
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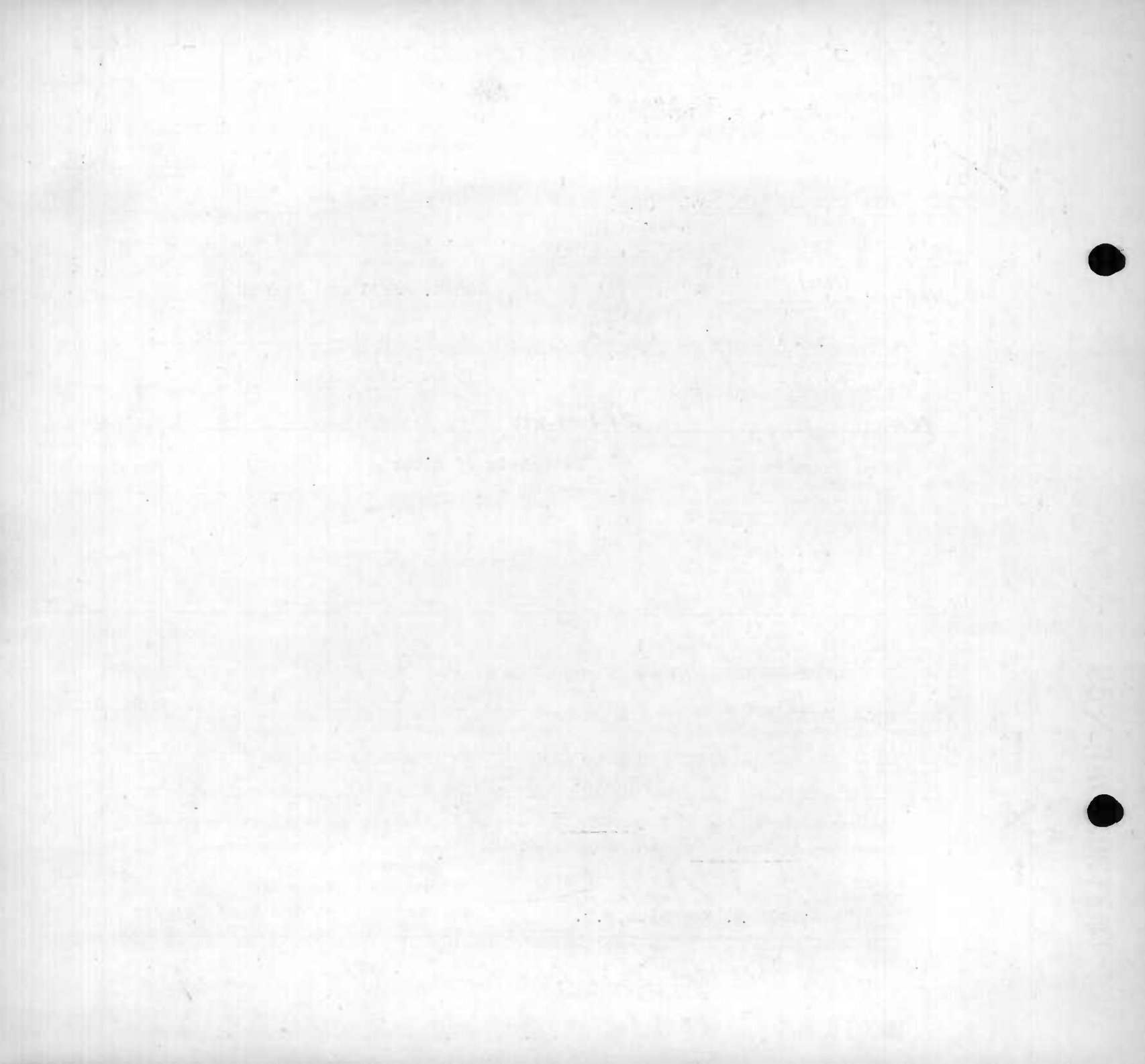
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 4485</u>	
H-435 71 4485		BIRTH NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
HOLTMAN, ALBERT FREDERICK		MAY 8, 1971		9:10P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
ST. AGNES HOSPITAL WILKENS & CATON AVENUES BALTIMORE, MARYLAND 21229		MARYLAND			
C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER		538 BRUNSWICK STREET (21223) 2006			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	03 11 07	64	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
GAS STATION ATTENDANT (RETIRED)				MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Adolphus Holtman		Rikie Korlie		UNITED STATES	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		212-07-7630		ST. AGNES HOSPITAL RECORDS	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Upper Gastrointestinal Bleeding					
(B) Duodenal Ulcer DUE TO, OR AS A CONSEQUENCE OF:					
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
Pul. emphysema					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from MAY 6 1971 to MAY 8 1971 that (X) (we) last saw the deceased alive on MAY 8 1971 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
DR. SALVADOR QUIROZ				MAY 8, 1971	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		5-12-71		Loudon Park	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
MAY 10 1971		George A. Schwab, M.D.		George A. Schwab, F.H. 2101 Frederick Ave.	



BIRTH NO.		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		5. USUAL RESIDENCE	
1. NAME OF DECEASED (Type or Print)		Known <input type="checkbox"/> Month Day Year Hour		Month Day Year Hour		A. STATE B. COUNTY	
WALTER H. BACKHAUS		Estimated <input type="checkbox"/> M.		May 8, 1971 10:05 A.		Maryland	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
FULL NAME OF HOSPITAL OR INSTITUTION		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
BON SECOURS HOSPITAL (DOA)							
6. SEX		7. RACE		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. DATE OF BIRTH		10. AGE (In years lost birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
(1906) 64		unknown		Berlin, Germany		USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
Track Driver				unknown		Dore (unknown)	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS	
No		214-09-9060		Mrs. Backhaus		440 S. Smallwood St.	
19. 571.9		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		Cirrhosis of Liver					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C)					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23.		I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED			
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER					
Ronald N. Kornblum, M.D.		ASSOCIATE MEDICAL EXAMINER					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		5/11/71		Meadowridge Mem'l Rk. Balto. Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
MAY 10 1971		Geo. L. Schuchman, Jr.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

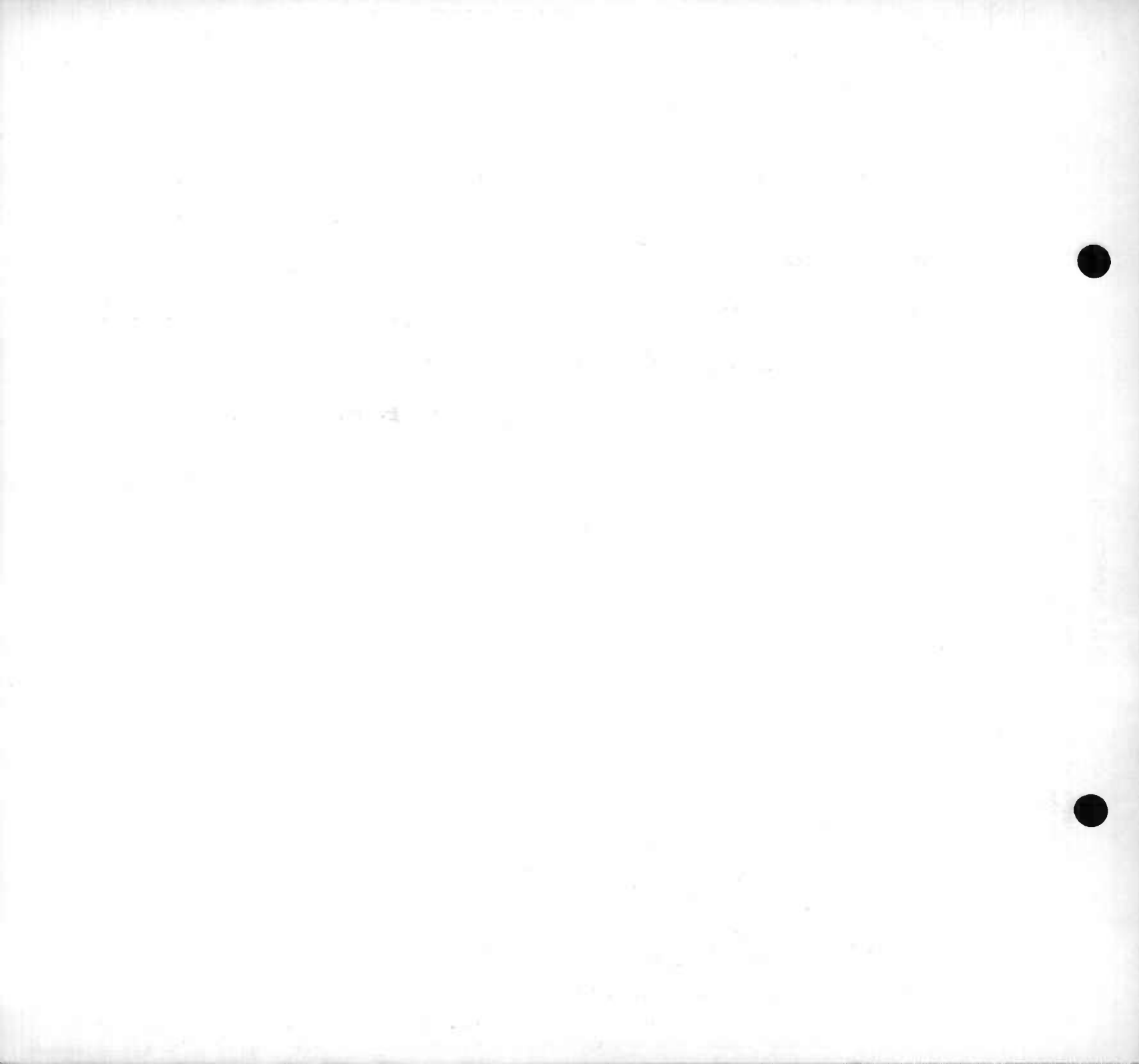
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 4487</u>			
BIRTH NO. <u>B-536 71 4487</u>				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>MARY A BENNETT</u>				2. DATE AND HOUR OF DEATH <u>5-8-71</u> <u>4 15</u> P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>34 Bon Secours Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Pratt St.</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>821 W. Pratt St.</u> <u>2102</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/26/99</u>	9. AGE (In years last birthday) <u>72</u>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Ellicott City, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Adolphus Holtman</u>				14. MOTHER'S MAIDEN NAME <u>unknown Rikie Korli</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-62-9343</u>		17. INFORMANT <u>Arthur Vecchioni</u>		ADDRESS <u>Baltimore 21221</u>	
18. <u>410.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>CARDIOGENIC SHOCK + CHF.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>ACUTE MYOCARDIAL INFARCTION</u> <u>HASCU</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>5</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>5-8-71</u> to <u>5-8-71</u> that (I) (we) last saw the deceased alive on <u>5-8-71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u> <u>MD</u> DEGREE				23B. DATE SIGNED <u>5-8-71</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <u>MARCELINO F. ALBUERNE MD</u> DEGREE				23D. ADDRESS <u>7935 PIPERS PATH JEN BURNIE MD 21061</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/14/71</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Green Haven</u>		24D. LOCATION (City, town, or county) (State) <u>Jen Burnie, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1971</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>[Signature]</u> ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

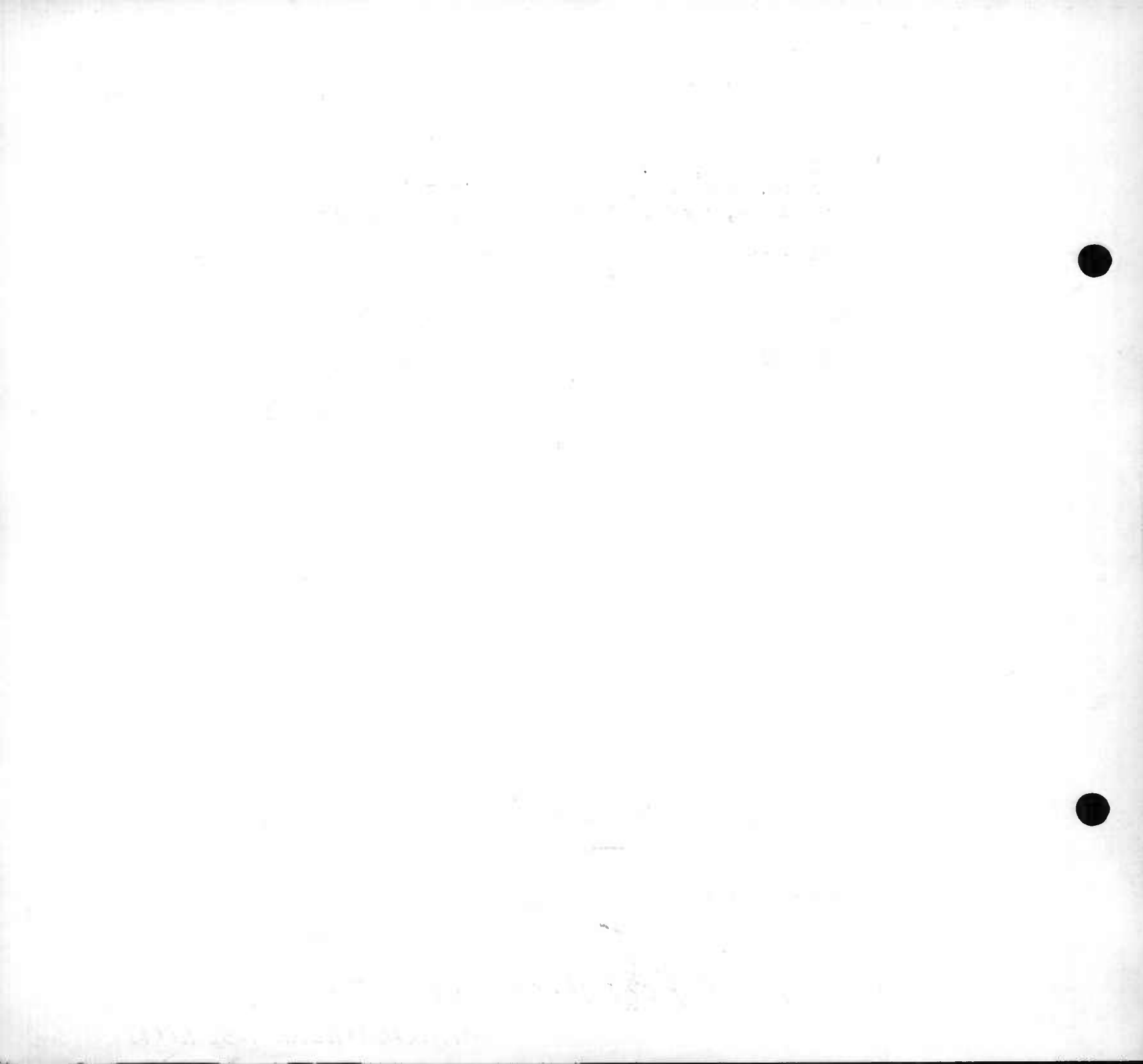
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>71 4488</u>	
BIRTH NO. <u>S-160 71 4488</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Virginia L. Spear</u>		2. DATE AND HOUR OF DEATH <u>5/12/71</u> #3 <u>1:35</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>MD</u> B. COUNTY	
C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <u>3701 St. Paul Street</u>		<u>12 D1</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/7/14</u>	9. AGE (in years last birthday) <u>57</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife - Sales</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Real Estate</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>MARION Oklham Lewis</u>		14. MOTHER'S MAIDEN NAME <u>Clara Reed</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Franklin E. Spear, Same as #4</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Respiratory Insufficiency</u> <u>Pleural effusion</u> <u>Cancerous @ Lung</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> and that (I) (we) last saw the deceased alive on <u>19</u> and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>George H. Finney Jr.</u>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>George H. Finney Jr.</u>		23D. ADDRESS <u>5820 York Rd Baltimore MD</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>May 10, 1971</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>	
24D. LOCATION <u>Pikesville, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1971</u>			
25B. NAME OF REGISTRAR <u>Wm. Cook-Brooks</u>		25C. FUNERAL DIRECTOR <u>Towson, Maryland</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>71 4489</u>	
<p>BIRTH NO.</p> <p><u>C-615 71 4489</u></p>		<p>1. NAME OF DECEASED (Type or Print)</p> <p>Thomas CARABINAS (CARABINOS)</p>		<p>2. DATE AND HOUR OF DEATH</p> <p>May 8, 1971 1:40 P.M.</p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p>Midtown Home, Inc. 808 St. Paul Street Baltimore, Maryland 21202</p>				<p>4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)</p> <p>A. STATE B. COUNTY</p> <p>Maryland</p>			
<p>5. SEX</p> <p>M</p>				<p>6. RACE</p> <p>Caucasian</p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	
<p>8. DATE OF BIRTH</p> <p>9/12/88</p>		<p>9. AGE (In years last birthday) 82</p>		<p>10. UNDER 1 Yr. Months Days Hours Min.</p>		<p>11. BIRTHPLACE (State or foreign country)</p> <p>UNKNOWN</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p>SEAMEN</p>				<p>10B. KIND OF BUSINESS OR INDUSTRY</p> <p>UNKNOWN</p>			
<p>13. FATHER'S NAME</p> <p>UNKNOWN</p>				<p>14. MOTHER'S MAIDEN NAME</p> <p>UNKNOWN</p>			
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p>UNKNOWN</p>				<p>16. SOCIAL SECURITY NO.</p> <p>091 16 6964</p>		<p>17. INFORMANT</p> <p>midtown Home Inc 808 St Paul St</p>	
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.)</p> <p>CAUSE OF DEATH</p> <p>Cardio genic Shock</p> <p>(A) IMMEDIATE CAUSE</p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p> <p>Acute myocardial infarction</p> <p>(B) Antecedent Causes</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>Diabetes Mellitus</p>				<p>19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p> <p>II</p>			
<p>19A. DATE OF OPERATION</p> <p>0</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No)</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p> <p><input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>21D. TIME OF INJURY (APPROX.)</p> <p>(Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>22. I certify that (I) (this hospital) attended the deceased from May 25 1963 to May 8 1971 that (I) (we) last saw the deceased alive on May 8 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.</p>			
<p>23A. SIGNATURE</p> <p>William Applefeld</p>				<p>23B. DATE SIGNED</p>		<p>23C. PHYSICIAN'S NAME (Type)</p> <p>WILLIAM APPLEFELD</p>	
<p>23D. ADDRESS</p> <p>6615 Reisterstown Rd</p>				<p>24A. BURIAL CREMATION, REMOVAL (Specify)</p> <p>BURIAL</p>			
<p>24B. DATE</p> <p>5/11/71</p>		<p>24C. NAME OF CEMETERY OR CREMATORY</p> <p>PROSPECT HILL</p>		<p>24D. LOCATION (City, town, or county) (State)</p> <p>TOWSON MD</p>		<p>25A. DATE REC'D BY HEALTH DEPT.</p> <p>MAY 10 1971</p>	
<p>25B. NAME OF REGISTRAR</p> <p>John B. ...</p>		<p>25C. FUNERAL DIRECTOR</p> <p>WM COOK Brooks TOWSON 1050 Park Rd TOWSON</p>		<p>25D. ADDRESS</p>			



Mundell, Phyllis
142-21-68

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

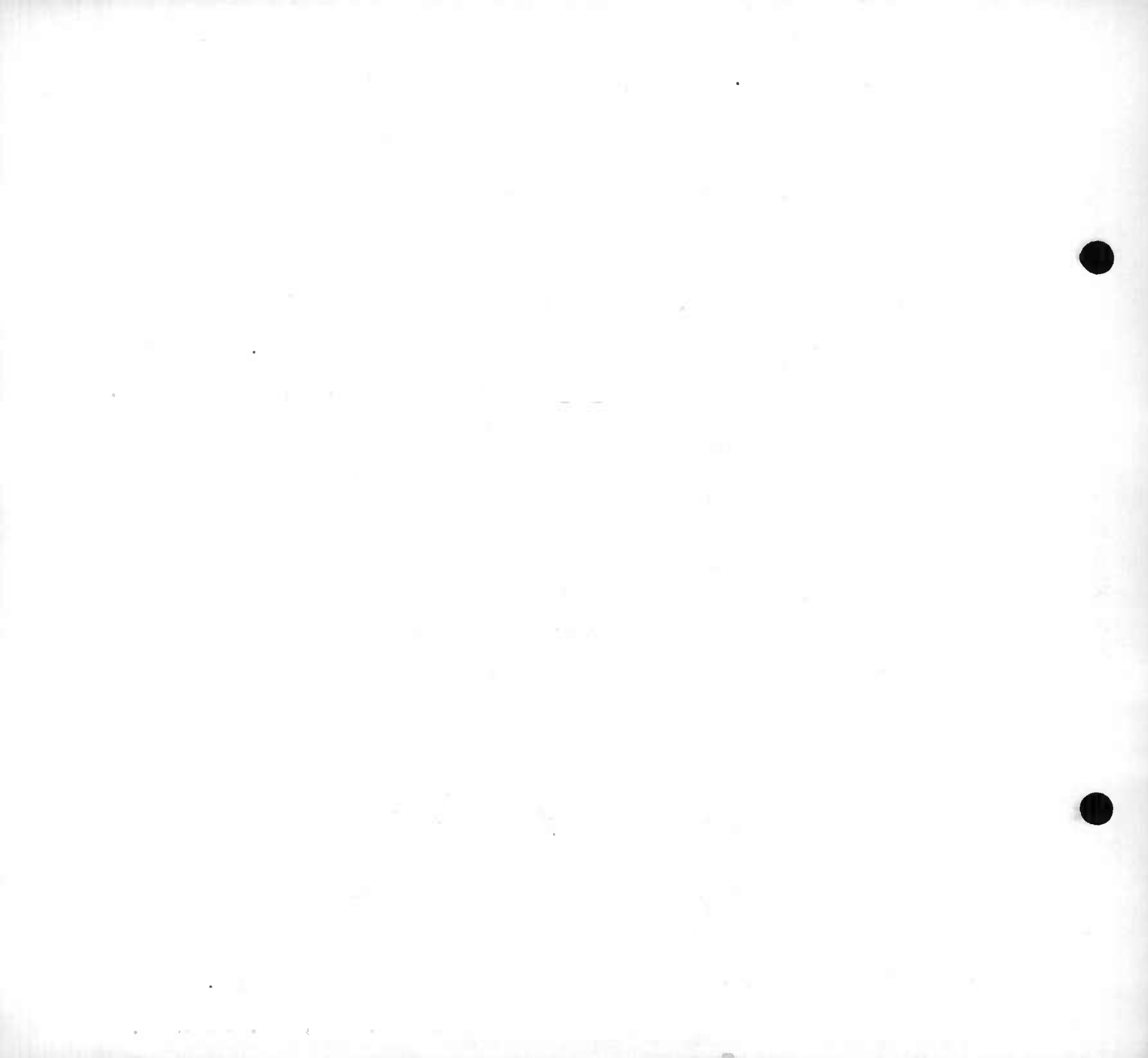
Baltimore City Health Department				CERTIFICATE OF DEATH		REG. NO. 71 4490	
BIRTH NO. 171 4490		1. NAME OF DECEASED (Type or Print) PHYLLIS MUNDELL		2. DATE AND HOUR OF DEATH 6 May 71 3 PM		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. A. CO			
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN HANOVER		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
33				E. STREET AND NUMBER RT 2 BOX 70		5200	
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-5-51		9. AGE (In years last birthday) 19	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory Worker		10B. KIND OF BUSINESS OR INDUSTRY Textile Co.		11. BIRTH PLACE (State or foreign country) Hanover, Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES MUNDELL				14. MOTHER'S MAIDEN NAME VICTORIA EDWARDS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Victoria Mundell - Hanover Md.			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				A. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Yellow Atrophy Liver		5 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				B. ? INH vs ? Serum Hepatitis		8 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) I APPROX		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5/1 19 71 to 5/6 19 71 that (I) (we) last saw the deceased alive on 5/6 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Gerald J. Elfен				23B. DATE SIGNED 5/6/71		23C. PHYSICIAN'S NAME (Type) GERALD J. ELFEN	
23D. ADDRESS THE JOHNS HOPKINS HOSPITAL							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/11/71		24C. NAME of CEMETERY or CREMATORY Mt. Pilgrim Cem.		24D. LOCATION (City, town, or county) (State) Hanover AA Co. Md	
25A. DATE REC'D AT HEALTH DEPT. MAY 10 1971				25B. FUNERAL DIRECTOR ADDRESS Russell S. Oden - Balto. Md.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 4491	
BIRTH NO. D-435 71 4491		1. NAME OF DECEASED (Type or Print) Lillian G. Baldwin		2. DATE AND HOUR OF DEATH 5/4/71 7p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION BOLTON HILL NURSING HOME		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Operator		10B. KIND OF BUSINESS OR INDUSTRY L. Gordon & Son		8. DATE OF BIRTH 9-3-86 9. AGE (in years last birthday) 84 yrs	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Robert Lafferty	
14. MOTHER'S MAIDEN NAME Mary C. Seidenstricker		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-01-5450	
17. INFORMANT Miss Florence Orman		ADDRESS 3106 Weaver Ave. 21214		18. Admission Record	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.31				(A) IMMEDIATE CAUSE arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF: years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II				(B) generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: years	
				(C) peripheral vascular disease years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Postoperative left ventricular decompensation				3/71	
19A. DATE OF OPERATION 3/3/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED gastroesophageal reflux		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/19 19 71 to 5/4 19 71 that (I) (we) last saw the deceased alive on 5/4 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature]				23B. DATE SIGNED 5/5/71	
23C. PHYSICIAN'S NAME (Type) ALAN H. MACHT M.D.		23D. ADDRESS 2 E. Pearl St. Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/8/71		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR Robert J. Taylor, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214			
25D. ADDRESS					

VS MAY 10 1971



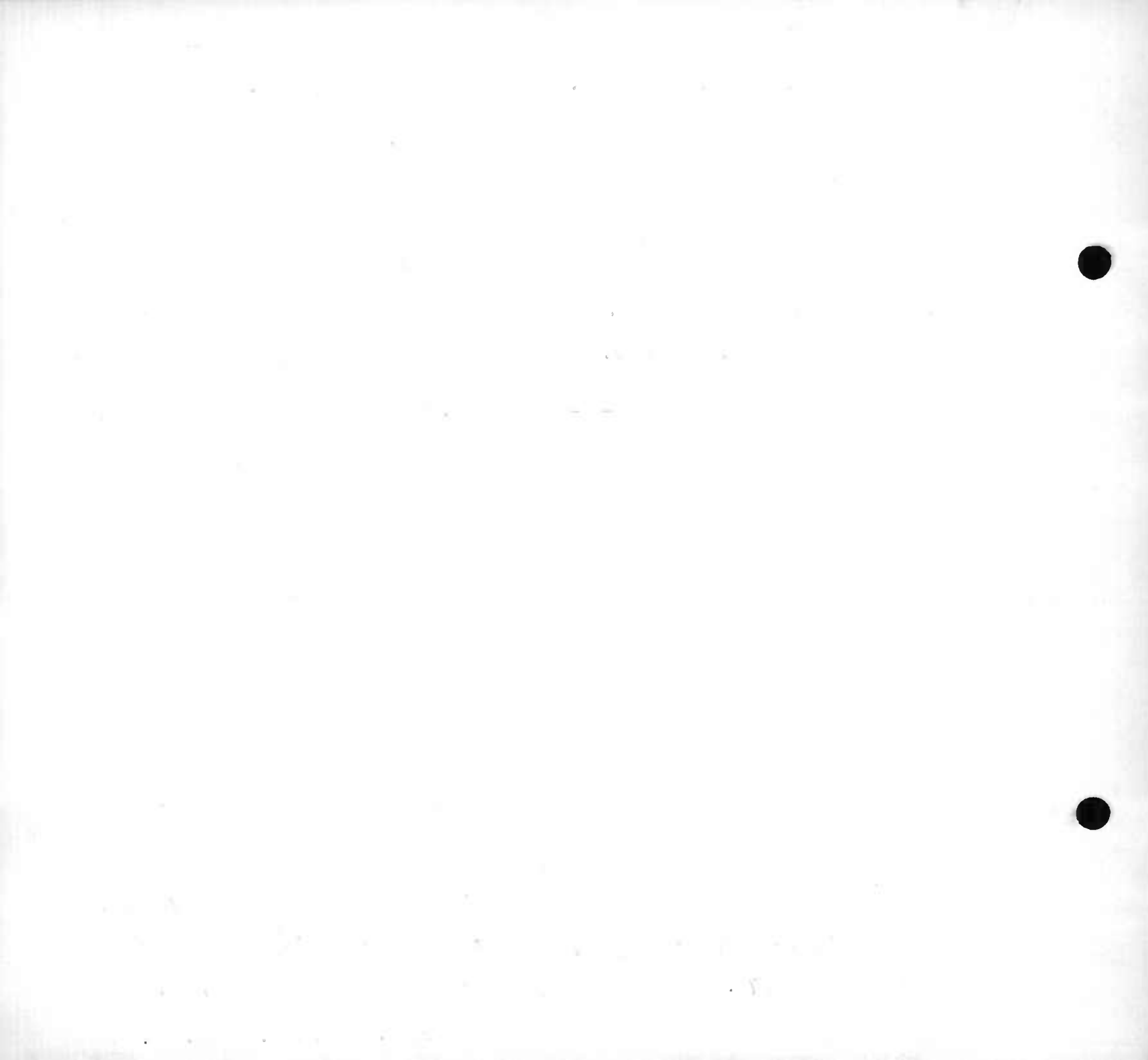
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>71 4492</u>	
BIRTH NO. <u>S-120 71 4492</u>		1. NAME OF DECEASED (Type or Print) <u>Lena Mary Svec</u>	
2. DATE AND HOUR OF DEATH <u>May 5, 1971</u> <u>8:40</u> A.M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u>		5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>4/23/18</u> 9. AGE (in years last birthday) <u>53</u>	
E. STREET AND NUMBER <u>930 Southwick Drive</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife Receptionist</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Otto Scharf</u>		14. MOTHER'S MAIDEN NAME <u>Rose Bretzel</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Records- US PHS Hospital, Balto, Md.</u>		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Upper & lower gastrointestinal bleeding</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Colon adenomas</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Multiple myelomas</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Weeks</u> <u>Mos.</u> <u>1 yr.</u>	
19A. DATE OF OPERATION <u>Mar. 7 1971</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>yes</u>	
20A. AUTOPSY? (Yes or No) <u>yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Mar. 7 1971</u> to <u>May 5 1971</u> that (I) (we) last saw the deceased alive on <u>May 5 1971</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Samuel P. Ward, M.D.</u>		23B. DATE SIGNED <u>5/5/71</u>	
23C. PHYSICIAN'S NAME (Type) <u>Samuel P. Ward, Surgeon (R)</u>		23D. ADDRESS <u>US PHS Hospital, Balto, Md. 21211</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>5/8/71</u>	
24C. NAME of CEMETERY or CREMATORY <u>Moreland Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1971</u>		25B. NAME OF REGISTRAR <u>Robert J. Fisher, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc.</u>		ADDRESS <u>5305 Harford Rd.</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 71 4493	
BIRTH NO. L-200 71 4493		1. NAME OF DECEASED (Type or Print) IRVIN H. LOOCK, JR.			
2. DATE AND HOUR OF DEATH May 6, 1971.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 1614 Heathfield Road		A. STATE Md.		B. COUNTY	
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH March 18, 1918		9. AGE (In years last birthday) 53		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bractor Operator Dispatcher (E. Stewart Mitchell)		10B. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Irvin H. Loock, Sr.		14. MOTHER'S MAIDEN NAME Mildred Rixner Eiser	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. 218-05-3354		17. INFORMANT Mrs. Donna Loock	
18. CAUSE OF DEATH 23811		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Brain Tumor		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 MOS	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Brain Tumor		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/14 19 70 to 5 19 71 that (I) (we) last saw the deceased alive on 5/1 19 71 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Francis X. Carmody		23B. DATE SIGNED MAY 6, 1971		23C. PHYSICIAN'S NAME (Type) Francis X. Carmody, M.D.	
23D. ADDRESS 3201 N. Charles St.		23E. DEGREE DEGREE		23F. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5/8/71.		24C. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. MAY 10 1971		25B. NAME OF REGISTRAR Robert E. Sabey, R.D.	
25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25D. ADDRESS		25E. DATE	



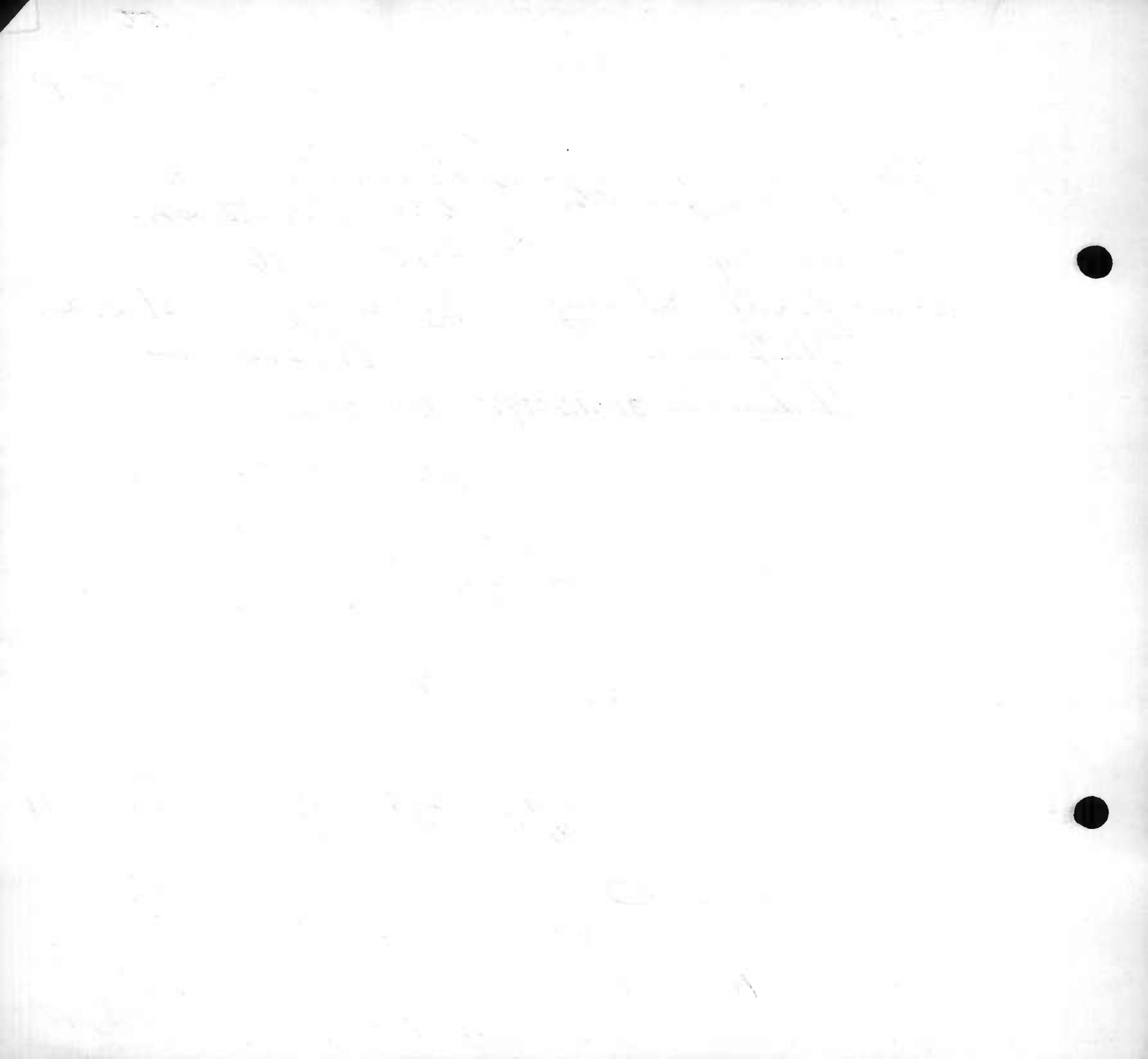
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

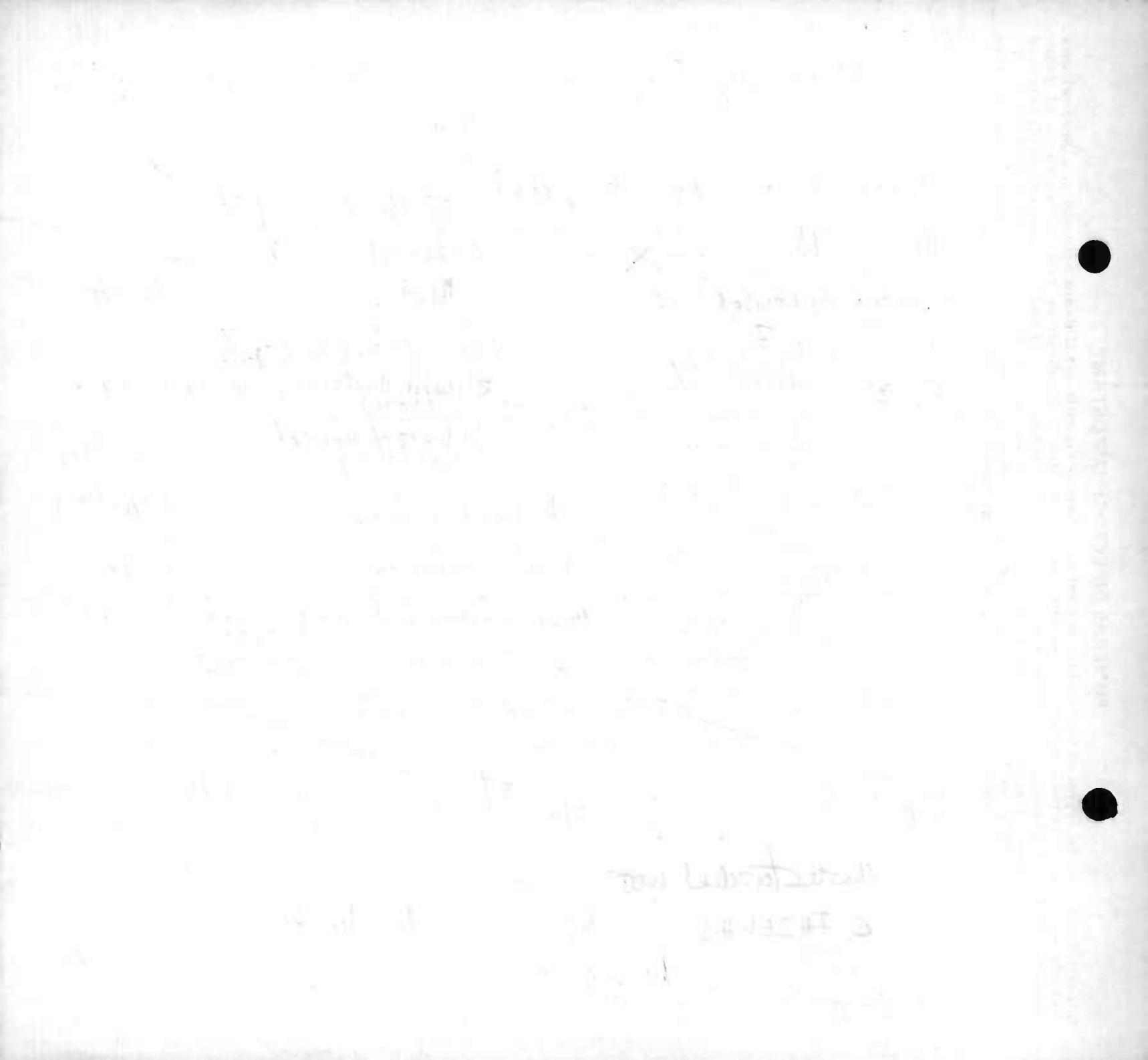
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 57 71 4495	
0-520 BIRTH NO.		71 4495		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Rhoda Owens</i>			2. DATE AND HOUR OF DEATH <i>5/5/71 5 P.M.</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>City</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Harbor View Nursing Cn</i> <i>1213 Light St</i>			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <i>F</i>			6. RACE <i>Caucasian</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/85</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Worked for self</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Sewing</i>		11. BIRTHPLACE (State or foreign country) <i>Kentucky</i>
13. FATHER'S NAME <i>Unknown</i>			14. MOTHER'S MAIDEN NAME <i>Unknown</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <i>Unknown</i>			16. SOCIAL SECURITY NO. <i>314-12-0898</i>		17. INFORMANT <i>NURSING HOME</i>
18. <i>4/12/71</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <i>0</i> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <i>NO</i> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from <i>2/3</i> 19 <i>69</i> to <i>5/5</i> 19 <i>71</i> that (I) (we) lost saw the deceased alive on <i>5/5</i> 19 <i>71</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <i>(P)</i> 23A. SIGNATURE <i>[Signature]</i> 23B. DATE SIGNED <i>5/6/71</i> 23C. PHYSICIAN'S NAME (Type) <i>ALAN H MAERT MD</i> 23D. ADDRESS <i>2 E Real St Baltimore</i> 24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i> 24B. DATE <i>5/17/71</i> 24C. NAME OF CEMETERY OR CREMATORY <i>GRK HAWN</i> 24D. LOCATION (City, town, or county) (State) <i>BALTO, Co. MD</i> 25A. DATE REC'D BY HEALTH DEPT. <i>MAY 10 1971</i> 25B. NAME OF REGISTRAR <i>[Signature]</i> 25C. FUNERAL DIRECTOR <i>[Signature]</i> ADDRESS <i>[Address]</i>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

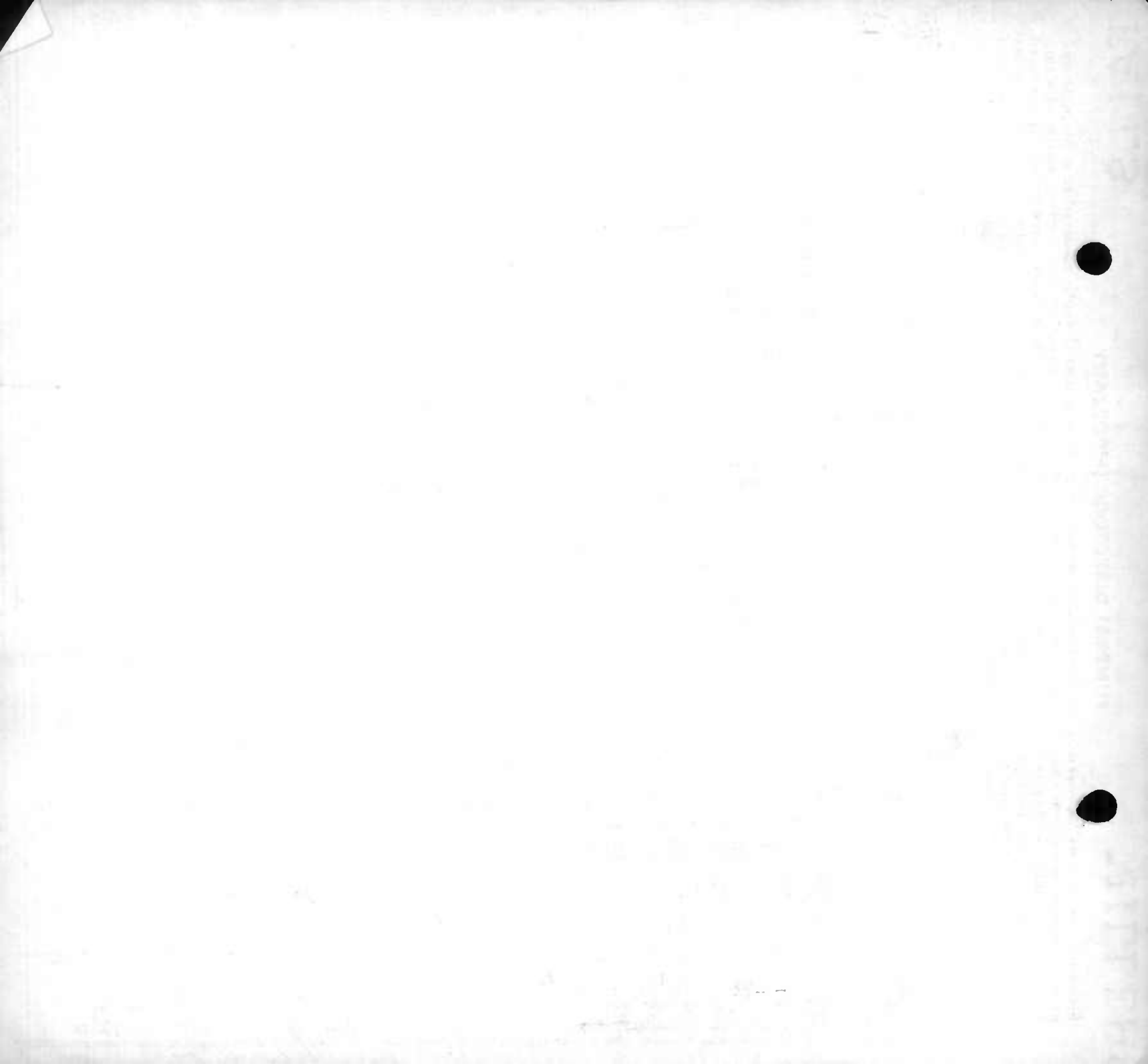
Baltimore City Health Department				REG. NO. 71 4486	
BIRTH NO. 171 4486		71 4486		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Mulcahy, Joseph S. Sr.		2. DATE AND HOUR OF DEATH May 6, 1971 9:15 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Union Memorial Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 516 W. 27 St.		1207	
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-20-91	9. AGE (In years last birthday) 80	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Income tax supervisor State of Md.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD.	
13. FATHER'S NAME William Mulcahy		14. MOTHER'S MAIDEN NAME Clara Elizabeth Watts			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216 09 7702		17. INFORMANT Richard Mulcahy (son)	
18. 430101		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Subarachnoid bleeding		2-3 hrs	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: Hypertension		Yrs (?)	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) pos. aneurism		Yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		huge abdominal aortic aneurism.		Yrs	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 5/6 19 71 to 5/6 19 71 that (1) (we) last saw the deceased alive on 5/6 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Charles Terzieski		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Typed) E. FAZEKAS		DEGREE MD.		23D. ADDRESS U. U. H.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-10-71		24C. NAME of CEMETERY or CREMATORY Meridown ridge	
24D. LOCATION (City, town, or county) (State) Howard Co Md		25A. DATE RECEIVED BY HEALTH DEPT. MAY 10 1971		25B. NAME OF REGISTRAR James E. Mulcahy	
25C. FUNERAL DIRECTOR Burges Funeral Home		ADDRESS Balto., Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				71 4497		REG. NO.	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>Arrington, Mary A.</u>				2. DATE AND HOUR OF DEATH <u>May 6, 1971</u> <u>1:00</u> <u>A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
5. SEX <u>Female</u> 6. RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>02-27-90</u> 9. AGE (In years last birthday) <u>81</u> 10. UNDER 1 Yr. <u>Months</u> <u>Days</u> 11. UNDER 24 Hrs. <u>Hours</u> <u>Min.</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None (Housewife)</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>John William Bailey</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ann Hickey</u>			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>216 10 92620</u>		17. INFORMANT <u>Milton Arrington</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CVA</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>May 1</u> 19 <u>71</u> to <u>May 6</u> 19 <u>71</u> that (I) (we) lost saw the deceased alive on <u>May 6</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>John Ohe</u>				23B. DATE SIGNED <u>May 6, 71</u>		23C. PHYSICIAN'S NAME (Type) <u>Tohrv OHE MD</u>	
23D. ADDRESS <u>Union Memorial Hospital</u>				24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>5-8-71</u>		24C. NAME of CEMETERY or CREMATORY <u>Meadowridge Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Howard County Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>MAY 10 1971</u>	
25B. NAME OF REGISTRAR <u>John Ohe</u>		25C. FUNERAL DIRECTOR <u>Burgess Funeral Home</u>		25D. ADDRESS <u>Baltimore Maryland</u>		25E. DATE <u>May 10 1971</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 71 4498	
D-400 71 4498		BIRTH NO. 70-17245		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) RODERICK K. DOLLE			2. DATE AND HOUR OF DEATH MAY 7, 1971 11:50 P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL 33 IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION 6-1-71			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore		
5. SEX M 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 9/29/70 9. AGE (In years last birthday) 17 10. UNDER 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child			11. BIRTHPLACE (State or foreign country) Maryland		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Carroll Dolle			14. MOTHER'S MAIDEN NAME Elizabeth Moss		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		
17. INFORMANT George Gloria F. Moss, Jr. ADDRESS 21227			18. Mrs. Gloria F. Moss, Jr. 1139 Gloria Ave.		
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 207.014-009.2			CAUSE OF DEATH (A) IMMEDIATE CAUSE acute leukemia DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). severe gastroenteritis			(C) DUE TO, OR AS A CONSEQUENCE OF:		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY (Yes or No) No			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, lawn, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from April 21 19 71 to May 7 19 71 that (I) (we) last saw the deceased alive on May 7 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Leslie P. Plotnick M.D.			23B. DATE SIGNED 5/7/71		
23C. PHYSICIAN'S NAME (Type) Leslie P. Plotnick			23D. ADDRESS Johns Hopkins Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 5-11-1971		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Maryland		24E. STATE (State) Maryland			
25A. DATE REC'D BY HEALTH DEPT. MAY 10 1971			25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		
25C. FUNERAL DIRECTOR Howard H. Hubbard			25D. ADDRESS 4107 Wilkens Ave. 2122.9		

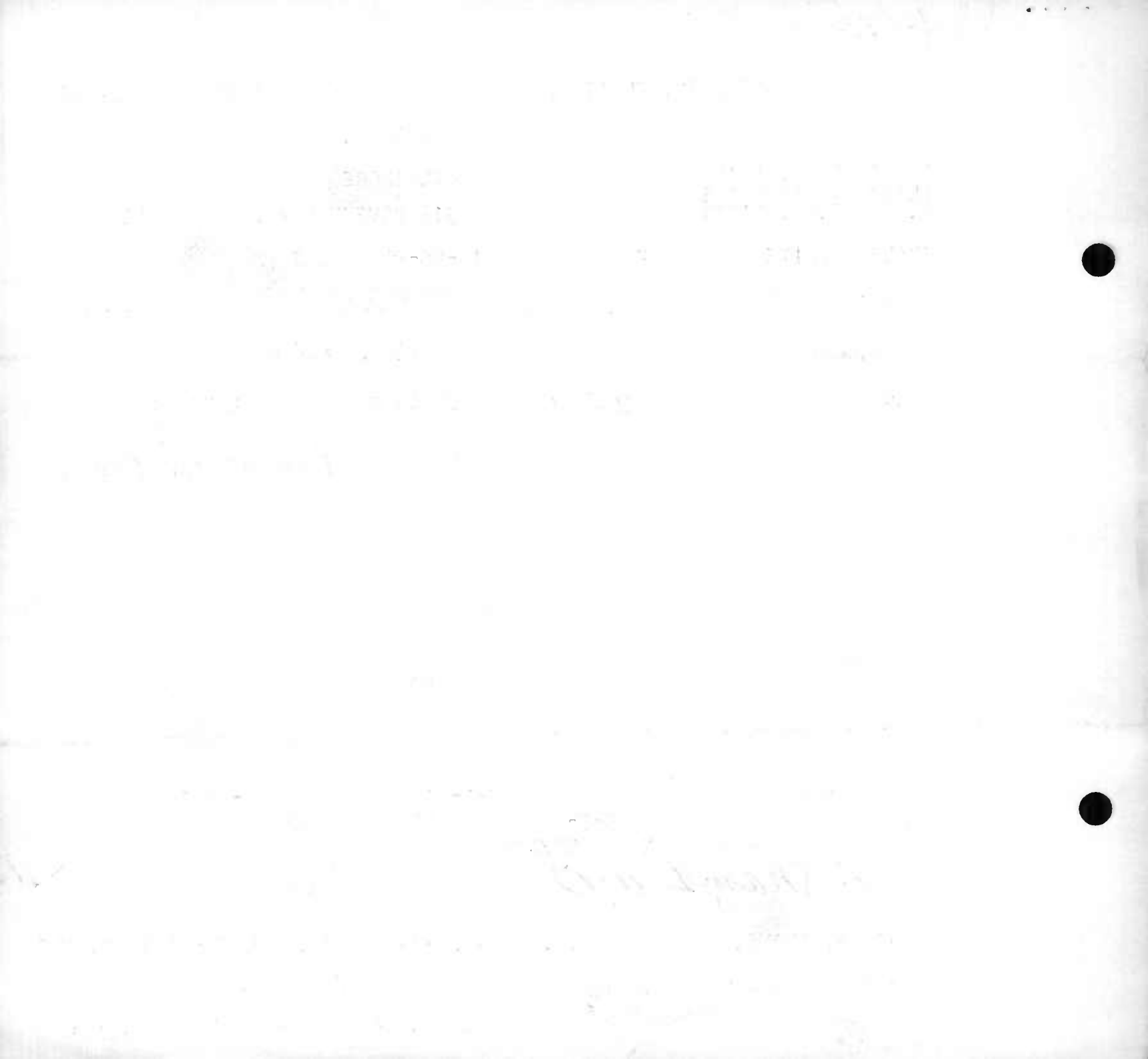
V.S. 153

6-1-71

M.H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-632 71 4488		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 71 4488	
BIRTH NO.			1. NAME OF DECEASED (Type or Print)		
GRETZNER, ELSIE V.			2. DATE AND HOUR OF DEATH MAY 5, 1971 3:45A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL WILKENS & CATON AVE BALTIMORE, MD. 21229			A. STATE MARYLAND, B. COUNTY		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER 516 COVENTRY RD.			21229 253		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-05-04	9. AGE (In years last birthday) -67 66	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier		10B. KIND OF BUSINESS OR INDUSTRY Harry M. Stevens		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Lola L. Tomlinson	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-09-1350		17. INFORMANT ST AGNES HOSP WILKENS & CATON AVE	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: terminal ca of Tru lung.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (natally medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 5-5-71 19 to 5-5-71 19 that (X) (we) last saw the deceased alive on 5-5-71 19 and that in my (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.					
23A. SIGNATURE A-Shams, M.D.		23B. DATE SIGNED 5-5-71		23C. PHYSICIAN'S NAME (Type) DR. A. SHAMS, M.D.	
23D. ADDRESS ST. AGNES HOSP. WILKENS & CATON AVE		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 5-8-71		24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE WHEN HEALTH DEPT. RECEIVED MAY 10 1971		25B. NAME OF REGISTRAR John C. Miller		25C. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Rd, 21206	



1

H-400 71 4500 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 71 4500

BIRTH NO.

1. NAME OF DECEASED (Type or Print) James L. Hill

2. DATE OF DEATH Known ☒ Estimated ☐ Month 5 Day 9 Year 71 Hour 10:00 p.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) OR INSTITUTION Bon Secours Hospital

3. DATE PRONOUNCED DEAD Month 5 Day 9 Year 71 Hour 10:00 p.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto.

6. SEX male 7. RACE Negro 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES ☒ NO ☐

9. DATE OF BIRTH 10-29-28 10. AGE (In years last birthday) 42 11. BIRTHPLACE (State or foreign country) Green County, Va. 12. CITIZEN OF WHAT COUNTRY? U.S.A. 13. FATHER'S NAME JOSEPH Hill 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ? 14B. KIND OF BUSINESS OR INDUSTRY ? 15. MOTHER'S MAIDEN NAME Lucy Williams

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES 1950-1956 17. SOCIAL SECURITY NO. 820-20-4948 18. INFORMANT ADDRESS MANIE Williams 2010 W. Franklin St.

19. CAUSE OF DEATH 431.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Intracerebral hemorrhage (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 22F. HOW DID INJURY OCCUR?

23. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ ASSOCIATE MEDICAL EXAMINER ☒ DATE SIGNED 5/10/71

ACTUAL SIGNATURE Peter Lipkovic, M.D. EXAMINER'S NAME (Type)

24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 5-13-71 24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem 24D. LOCATION (City, town, or county) (State) Anne Arundel Coun. Md.

25A. DATE REC'D BY HEALTH DEPT. MAY 11 1971 25B. NAME OF REGISTRAR Robert E. Fisher, R.D. 25C. FUNERAL DIRECTOR Calvin D. Seneygo 1412 E. Preston St.

VS 151-REV. 1/1/68

1350

10-20-58

10-20-58

Superintendent

10-20-58